

FOR STATE  
HEALTH DEPT.

7064

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gregory Scott Anderson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-15-58</b>
9. AGE (in years last birthday) <b>5</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William John Anderson</b>	
14. MOTHER'S MAIDEN NAME <b>Doris Ellen Longanecker</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Father; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of food</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aspiration of vomited food</b>	
20c. TIME OF INJURY Month, Day, Year <b>2.00</b> hour <b>306</b> p. m. <b>6-10- 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>private home</b>	20f. (City or town) (County) (State) <b>College Park pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 10 1959</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

MEDICAL CERTIFICATION

FOR STATE  
HEALTH DEPT.

1

THE STATE OF NEW YORK  
OFFICE OF THE COMMISSIONER OF HEALTH  
ALBANY, N. Y.  
JANUARY 1, 1900

NAME OF PATIENT		AGE		SEX		RACE		RELIGION		EDUCATION		OCCUPATION		RESIDENCE		DATE OF BIRTH		DATE OF DEATH		CAUSE OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH	
John T. Finney, Jr.		35		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Mary J. Finney		32		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
William J. Finney		30		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Elizabeth J. Finney		28		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Robert J. Finney		25		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Margaret J. Finney		22		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Thomas J. Finney		20		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Anna J. Finney		18		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Charles J. Finney		15		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Elizabeth J. Finney		12		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
John T. Finney, Jr.		35		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Mary J. Finney		32		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
William J. Finney		30		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Elizabeth J. Finney		28		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Robert J. Finney		25		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Margaret J. Finney		22		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Thomas J. Finney		20		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Anna J. Finney		18		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Charles J. Finney		15		Male		White		Roman Catholic		High School		Farmer		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	
Elizabeth J. Finney		12		Female		White		Roman Catholic		High School		Homemaker		New York, N. Y.		Jan 1, 1900		Jan 1, 1900		Heart Disease		Home		Natural		No	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07040

7065

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>	c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7608 Kipling Parkway</u>		d. STREET ADDRESS <u>7608 Kipling Parkway</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEVY CHASE DIX-ANDREWS</u>		4. DATE OF DEATH Month Day Year <u>June 5 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salt Lake City, Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Queen Dix</u>		14. MOTHER'S MAIDEN NAME <u>Maria L Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Jane Bedke</u>		Address <u>7608 Kipling Parkway District Heights</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Myeloma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>1 Year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 19 <u>58</u> , to <u>June 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 June</u> , 19 <u>59</u> , and that death occurred at <u>12:59 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7200-Mareboro Pike SE</u> DATE SIGNED <u>June 5, 1959</u>			
ACTUAL SIGNATURE <u>Sidney W. Lowry</u> M.D.		DATE SIGNED <u>June 5, 1959</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWRY MD.</u>		<u>WASHINGTON 28 DC.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or County) (State)
<u>Burial</u>	<u>6-9-59</u>	<u>Mt. Olivet</u>	<u>Salt Lake City Utah</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc. Wash. D. C.</u>		24a. REC'D BY REGISTRAR <u>June 8 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: 1945-10-15

5. Place of death: Home

6. Cause of death: Heart Disease

7. Date of birth: 1900-01-01

8. Place of birth: Baltimore, Md.

9. Occupation: Teacher

10. Signature of physician: Dr. J. K. Smith

11. Signature of registrar: John Doe

12. Date of registration: 1945-10-20

13. Place of registration: Baltimore, Md.

14. Signature of informant: John Doe

15. Date of information: 1945-10-15

16. Place of information: Baltimore, Md.

17. Signature of informant: John Doe

18. Date of information: 1945-10-15

19. Place of information: Baltimore, Md.

20. Signature of informant: John Doe

21. Date of information: 1945-10-15

22. Place of information: Baltimore, Md.

23. Signature of informant: John Doe

24. Date of information: 1945-10-15

25. Place of information: Baltimore, Md.

26. Signature of informant: John Doe

27. Date of information: 1945-10-15

28. Place of information: Baltimore, Md.

29. Signature of informant: John Doe

30. Date of information: 1945-10-15

31. Place of information: Baltimore, Md.

32. Signature of informant: John Doe

33. Date of information: 1945-10-15

34. Place of information: Baltimore, Md.

35. Signature of informant: John Doe

36. Date of information: 1945-10-15

37. Place of information: Baltimore, Md.

38. Signature of informant: John Doe

39. Date of information: 1945-10-15

40. Place of information: Baltimore, Md.

41. Signature of informant: John Doe

42. Date of information: 1945-10-15

43. Place of information: Baltimore, Md.

44. Signature of informant: John Doe

45. Date of information: 1945-10-15

46. Place of information: Baltimore, Md.

47. Signature of informant: John Doe

48. Date of information: 1945-10-15

49. Place of information: Baltimore, Md.

50. Signature of informant: John Doe

51. Date of information: 1945-10-15

52. Place of information: Baltimore, Md.

53. Signature of informant: John Doe

54. Date of information: 1945-10-15

55. Place of information: Baltimore, Md.

56. Signature of informant: John Doe

57. Date of information: 1945-10-15

58. Place of information: Baltimore, Md.

59. Signature of informant: John Doe

60. Date of information: 1945-10-15

61. Place of information: Baltimore, Md.

62. Signature of informant: John Doe

63. Date of information: 1945-10-15

64. Place of information: Baltimore, Md.

65. Signature of informant: John Doe

66. Date of information: 1945-10-15

67. Place of information: Baltimore, Md.

68. Signature of informant: John Doe

69. Date of information: 1945-10-15

70. Place of information: Baltimore, Md.

71. Signature of informant: John Doe

72. Date of information: 1945-10-15

73. Place of information: Baltimore, Md.

74. Signature of informant: John Doe

75. Date of information: 1945-10-15

76. Place of information: Baltimore, Md.

77. Signature of informant: John Doe

78. Date of information: 1945-10-15

79. Place of information: Baltimore, Md.

80. Signature of informant: John Doe

81. Date of information: 1945-10-15

82. Place of information: Baltimore, Md.

83. Signature of informant: John Doe

84. Date of information: 1945-10-15

85. Place of information: Baltimore, Md.

86. Signature of informant: John Doe

87. Date of information: 1945-10-15

88. Place of information: Baltimore, Md.

89. Signature of informant: John Doe

90. Date of information: 1945-10-15

91. Place of information: Baltimore, Md.

92. Signature of informant: John Doe

93. Date of information: 1945-10-15

94. Place of information: Baltimore, Md.

95. Signature of informant: John Doe

96. Date of information: 1945-10-15

97. Place of information: Baltimore, Md.

98. Signature of informant: John Doe

99. Date of information: 1945-10-15

100. Place of information: Baltimore, Md.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07041

7118

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>DISTRICT OF COLUMBIA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hosp. Andrews</u>		d. STREET ADDRESS <u>APT 3 4230 Livingston Rd SE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Armstrong</u> Last <u></u>		4. DATE OF DEATH Month <u>Jun</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Ca</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 May 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. Jailer</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 1888-1927</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Helen L. Armstrong</u>		Address <u>APT 3 4230 Livingston Rd SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>203x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Multiple Myeloma</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 June 1959</u> to <u>13 June 1959</u> , that I last saw the deceased alive on <u>13 June 1959</u> , and that death occurred at <u>0215M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Reginald P. McManus</u> M.D.		DATE SIGNED <u>13 June 1959</u>	
PHYSICIAN'S NAME (Type) <u>REGINALD P. McMANUS, CAPT, USAF (MC)</u> <u>USAF HOSPITAL ANDREWS AFB, WASH 25, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael J. Rinaldi</u>		ADDRESS <u>Rinaldi Funeral Home, Inc. 816 H St., N. E., Wash., DC</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Knaus</u>	



CERTIFICATE OF DEATH

07042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Geo. George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Elkhart Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>millersburg, Indiana</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		d. STREET ADDRESS <u>Elkhart 52X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2614 Kirkwood Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ENOLA SUSAN BARNARD</u>		4. DATE OF DEATH Month Day Year <u>JUNE 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12, 1872</u>
9. AGE (In years last birthday) <u>86 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Roseer</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Angela Bonard - Hyattsville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>TERMINAL PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO <u>36 HOURS</u> (c) <u>ESSENTIAL HYPERTENSION.</u> DUE TO <u>5 YEARS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/6</u> , 19 <u>59</u> , to <u>6/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/6</u> , 19 <u>59</u> , and that death occurred at <u>5:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hugh W. Irey</u>		ADDRESS (Street, city or town, state) <u>7105 - RIGGS RD.</u>	
PHYSICIAN'S NAME (Type) <u>HUGH W. IREY</u>		DATE SIGNED <u>6/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>June 7, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Paris</u>		22d. LOCATION (City, town, or county) (State) <u>Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07043

7066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>Bowie</b>	
3. NAME OF DECEASED (Type or print) First <b>Jessy</b> Middle <b>Oylin</b> Last <b>Barnwell</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-25- 55</b>
9. AGE (In years last birthday) <b>4</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Walter Edward Barnwell</b>	
14. MOTHER'S MAIDEN NAME <b>Emma May Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter Edw. Barnwell; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemangioma of thalamus</b> <b>228X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 24, 1959</b>	
22a. BURIAL, CREMATION, or other disposition <b>Transportation 6/25/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Trenton</b>		22d. LOCATION (City, town, or county) (State) <b>Georgia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch s Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

FOR STATE  
IN THE

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John J. [illegible]*

2. Date of Death: *June 26, 1933*

3. Place of Death: *[illegible]*

4. Age: *45*

5. Sex: *Male*

6. Race: *White*

7. Occupation: *[illegible]*

8. Cause of Death: *[illegible]*

9. Manner of Death: *[illegible]*

10. Signature of Medical Examiner: *[illegible]*

11. Date of Examination: *June 26, 1933*

12. Initials: *[illegible]*



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7119

CERTIFICATE OF DEATH

07044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
3. NAME OF DECEASED (Type or print) <u>Ida Estella</u> First Middle Last <u>Bean</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>72</u> yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW Domestic</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Retired Own Home</u>	
10a. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. FATHER'S NAME <u>Samuel D. Ogle</u>		12. MOTHER'S MAIDEN NAME <u>(nee Grove)</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. SOCIAL SECURITY NO. <u>281-01-4641</u>	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Occlusion</u> DUE TO (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>June 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C Van Vatta</u> M.D.		DATE SIGNED <u>6/30/59</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN VATT</u>		ADDRESS (Street, city or town, state) <u>Washington 28 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>		22d. LOCATION (City, town, or county) <u>Forestville</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u> ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7120

CERTIFICATE OF DEATH

07045

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> <del>None</del> b. COUNTY <u>Fri. George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AFB, WASH 25 DC</u> <u>NA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> <del>None</del>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS</u>				d. STREET ADDRESS <u>None Hunt Ave., Box 126</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>NEWBORN</u> Middle <u>BISHOP</u> Last <u>BISHOP</u>			<b>4. DATE OF DEATH</b> Month <u>JUNE</u> Day <u>8</u> Year <u>19 59</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASION</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 8, 1959</u>	
9. AGE (In years last birthday) yrs. <u>28</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>NORMAN R BISHOP</u>			
14. MOTHER'S MAIDEN NAME <u>EVELYN ROSE WILLIAMS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NA</u>				17. INFORMANT <u>FATHER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATUREITY</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>776x</u> DUE TO (c) <u>776x</u>				INTERVAL BETWEEN ONSET AND DEATH <u>28 MINUTES</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>0827</u> , 19 <u>59</u> , to <u>0855</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>0850</u> , 19 <u>59</u> , and that death occurred at <u>0855A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Douglas E. Pierce</u> M.D.				ADDRESS (Street, city or town, state) <u>USAF HOSPITAL ANDREWS</u> <u>Andrews AF Base, Wash 25, D.C.</u>			
DATE SIGNED <u>JUNE 8, 1959</u>				PHYSICIAN'S NAME (Type) <u>DOUGLAS E. PIERCE CAPT USAF MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashes disposed by District of Columbia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>DATE JUN 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

20 50 25 5XV0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07046

7067

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Gen. Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5700-39th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Black</b> Last <b>June</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-83</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>59</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Smith</b>		14. MOTHER'S MAIDEN NAME <b>Estella Applegate</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Hospital Records Cheverly-Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary embolus</b> DUE TO (c) <b>Generalized Carcinomatosis from rt breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>June 3</b>			
20f. (City or town) <b>June 3</b>		(County) <b>June 3</b>		(State) <b>June 3</b>			
21. I certify that I attended the deceased from <b>June 3</b> , 19 <b>59</b> , to <b>June 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 7</b> , 19 <b>59</b> , and that death occurred at <b>5:00 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7016 - Grep St. Seat Pleasant Md</b> DATE SIGNED <b>Max M. Herzberg</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Max M. Herzberg</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ewing Crematory</b>			
22d. LOCATION (City, town, or county) <b>Trenton, N.J.</b>		(State) <b>N.J.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Buschi, Sons Hyattsville Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7121  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 11, 12. See: Birth Cert. et  
CERTIFICATE OF DEATH

07047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Lusby's Lane, Box 15</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Leatrice ALBERTA BOLDEN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 1, 1958</u>	
9. AGE (In years last birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Reed Augusta Bolden</u>				14. MOTHER'S MAIDEN NAME <u>Eunice ALBERTA Tolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>FATHER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-10</u> , 19 <u>59</u> , to <u>6-11</u> , 19 <u>59</u> that I last saw the deceased alive on <u>6-11</u> , 19 <u>59</u> , and that death occurred at <u>9 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D. <u>Burgess, Md</u> <u>6-12-59</u> PHYSICIAN'S NAME (Type) <u>Richard H. Dobson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Bethel Church</u>		22d. LOCATION (City, town, or county) (State) <u>T.B., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>				ADDRESS <u>4339 hunt Pl., N.E., D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

2077409XV4



FOR STATE  
HEALTH DEPT.

7068

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 10a FilmG244 6-24-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heights</u>	
c. LENGTH OF STAY IN 1b <u>Readman</u>		d. STREET ADDRESS <u>987 - County Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Boteler</u> Middle <u>Barbara</u> Last		4. DATE OF DEATH <u>June 19 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1921</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13. FATHER'S NAME <u>Frederick S. McIntire</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-20-9362</u>	
17. INFORMANT <u>Thomas H. Boteler</u>		Address <u>987 County Rd Dist. Heights Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl.</u>		22d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. P. Chambers Co. Inc</u>		ADDRESS <u>517 11th St. S.E.</u>	
24a. REC'D BY REGISTRAR -DATE <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER, WHO IS TO SIGN THE SAME AND RETURN IT TO THE STATE HEALTH DEPARTMENT, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text and printed form fields follow. The form includes sections for patient information, cause of death, and examiner details.]*

1 ~~X~~  
FOR STATE  
HEALTH DEPT.

7049

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Pr. Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9412 Baltimore Boulevard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Doris Branson</b>		4. DATE OF DEATH <b>June 16 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-4-1924</b>
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Night club</b>	
11c. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		11d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred E. Branson</b>		14. MOTHER'S MAIDEN NAME <b>Lula Haynes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <b>Fred E. Branson</b>		18. ADDRESS <b>4516 Livingston Road, S.E. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO <b>916.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized burns of body</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burned during a fire in Club La Conga where she lived.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5.00 PM 6-16-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>College Park, Pr. Geo. Md.</b> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 16, 1959</b>	
22a. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Smithland, Md.</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Maloney</b>		ADDRESS <b>131-11th St. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>June 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneiss</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
RECORDS

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

DECEASED WAS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

DECEASED WAS: ☐ BORN IN NEW YORK ☐ BORN OUT OF NEW YORK

DECEASED WAS: ☐ A RESIDENT OF NEW YORK ☐ A RESIDENT OUT OF NEW YORK

DECEASED WAS: ☐ A NATURAL BORN CITIZEN ☐ A NATURALIZED CITIZEN

DECEASED WAS: ☐ A MEMBER OF THE ARMY ☐ A MEMBER OF THE NAVY

DECEASED WAS: ☐ A MEMBER OF THE AIR FORCE ☐ A MEMBER OF THE MARINE CORPS

DECEASED WAS: ☐ A MEMBER OF THE COAST AND GEODETIC SURVEY

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL GUARD ☐ A MEMBER OF THE NATIONAL RESERVE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL DEFENSE ☐ A MEMBER OF THE NATIONAL SERVICE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL YOUTH ☐ A MEMBER OF THE NATIONAL SERVICE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL YOUTH ☐ A MEMBER OF THE NATIONAL SERVICE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL YOUTH ☐ A MEMBER OF THE NATIONAL SERVICE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL YOUTH ☐ A MEMBER OF THE NATIONAL SERVICE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL YOUTH ☐ A MEMBER OF THE NATIONAL SERVICE

DECEASED WAS: ☐ A MEMBER OF THE NATIONAL YOUTH ☐ A MEMBER OF THE NATIONAL SERVICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7069

## CERTIFICATE OF DEATH

07050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Murry</b> Last <b>Breece</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Instrument Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Capitol Airlines</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jonathan Breece</b>		14. MOTHER'S MAIDEN NAME <b>Lucy White Bothwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW I</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>097-01-4576</b>	
17. INFORMANT <b>Delores B. Schmidt</b>		18. ADDRESS <b>2400 Parkway Cheverly, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROTIC HEART DISEASE 8 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1954</b> to <b>June 4, 1959</b> , that I last saw the deceased alive on <b>June 4, 1959</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman D. Comeau</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 62nd St.</b> DATE SIGNED <b>6/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>		22b. DATE THEREOF <b>6/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>College Point</b>		22d. LOCATION (City, town, or county) (State) <b>N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

# CERTIFICATE OF DEATH

1968

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. RACE [Illegible]</p>	
<p>5. DATE OF BIRTH [Illegible]</p>		<p>6. PLACE OF BIRTH [Illegible]</p>	
<p>7. DATE OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>14. SIGNATURE OF CORONER [Illegible]</p>	
<p>15. SIGNATURE OF JUDGE [Illegible]</p>		<p>16. SIGNATURE OF CLERK [Illegible]</p>	

1

TO BE FILLED IN BY THE CLERK OF THE COURT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G243 6/17/59 cap

CERTIFICATE OF DEATH

07051

7070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cheverley Conv, Nursing Home		d. STREET ADDRESS 4720 - Eastern Ave. N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATIE First S. BROOKE Middle Last		4. DATE OF DEATH June 11th. 1959 Month Day Year	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1875
9. AGE (In years last birthday) 83 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Levi Stely		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Philip S. Brooke		Address 4720 Eastern Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cerebro-Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 15 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957, to 6/11, 1959, that I last saw the deceased alive on 6/10, 1959, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M Trozzo Jr.		ADDRESS (Street, city or town, state) 3501 Hamilton St. Hyattsville, Md	
DATE SIGNED 6/11/59			
PHYSICIAN'S NAME (Type) FRANK M. TROZZO, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13, 1959	
22c. NAME OF CEMETERY OR CREMATORY Andrews Chapel		22d. LOCATION (City, town, or county) (State) McLean, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARTINE		2. SEX F	
3. DATE OF BIRTH 1911		4. PLACE OF BIRTH FRANCE	
5. CITY OF RESIDENCE BALTIMORE		6. OCCUPATION SEWING MACHINE REPAIRER	
7. MARITAL STATUS MARRIED		8. PLACE OF DEATH HOME	
9. DATE OF DEATH 1941		10. TIME OF DEATH 10:30 P.M.	
11. CAUSE OF DEATH CORONARY THROMBOSIS		12. MANNER OF DEATH NATURAL	
13. SIGNATURE OF PHYSICIAN J. H. [illegible]		14. SIGNATURE OF DECEASED [illegible]	
15. SIGNATURE OF WITNESSES [illegible]		16. SIGNATURE OF REGISTRAR [illegible]	
17. SIGNATURE OF CLERK [illegible]		18. SIGNATURE OF [illegible]	
19. SIGNATURE OF [illegible]		20. SIGNATURE OF [illegible]	
21. SIGNATURE OF [illegible]		22. SIGNATURE OF [illegible]	
23. SIGNATURE OF [illegible]		24. SIGNATURE OF [illegible]	
25. SIGNATURE OF [illegible]		26. SIGNATURE OF [illegible]	
27. SIGNATURE OF [illegible]		28. SIGNATURE OF [illegible]	
29. SIGNATURE OF [illegible]		30. SIGNATURE OF [illegible]	
31. SIGNATURE OF [illegible]		32. SIGNATURE OF [illegible]	
33. SIGNATURE OF [illegible]		34. SIGNATURE OF [illegible]	
35. SIGNATURE OF [illegible]		36. SIGNATURE OF [illegible]	
37. SIGNATURE OF [illegible]		38. SIGNATURE OF [illegible]	
39. SIGNATURE OF [illegible]		40. SIGNATURE OF [illegible]	
41. SIGNATURE OF [illegible]		42. SIGNATURE OF [illegible]	
43. SIGNATURE OF [illegible]		44. SIGNATURE OF [illegible]	
45. SIGNATURE OF [illegible]		46. SIGNATURE OF [illegible]	
47. SIGNATURE OF [illegible]		48. SIGNATURE OF [illegible]	
49. SIGNATURE OF [illegible]		50. SIGNATURE OF [illegible]	
51. SIGNATURE OF [illegible]		52. SIGNATURE OF [illegible]	
53. SIGNATURE OF [illegible]		54. SIGNATURE OF [illegible]	
55. SIGNATURE OF [illegible]		56. SIGNATURE OF [illegible]	
57. SIGNATURE OF [illegible]		58. SIGNATURE OF [illegible]	
59. SIGNATURE OF [illegible]		60. SIGNATURE OF [illegible]	
61. SIGNATURE OF [illegible]		62. SIGNATURE OF [illegible]	
63. SIGNATURE OF [illegible]		64. SIGNATURE OF [illegible]	
65. SIGNATURE OF [illegible]		66. SIGNATURE OF [illegible]	
67. SIGNATURE OF [illegible]		68. SIGNATURE OF [illegible]	
69. SIGNATURE OF [illegible]		70. SIGNATURE OF [illegible]	
71. SIGNATURE OF [illegible]		72. SIGNATURE OF [illegible]	
73. SIGNATURE OF [illegible]		74. SIGNATURE OF [illegible]	
75. SIGNATURE OF [illegible]		76. SIGNATURE OF [illegible]	
77. SIGNATURE OF [illegible]		78. SIGNATURE OF [illegible]	
79. SIGNATURE OF [illegible]		80. SIGNATURE OF [illegible]	
81. SIGNATURE OF [illegible]		82. SIGNATURE OF [illegible]	
83. SIGNATURE OF [illegible]		84. SIGNATURE OF [illegible]	
85. SIGNATURE OF [illegible]		86. SIGNATURE OF [illegible]	
87. SIGNATURE OF [illegible]		88. SIGNATURE OF [illegible]	
89. SIGNATURE OF [illegible]		90. SIGNATURE OF [illegible]	
91. SIGNATURE OF [illegible]		92. SIGNATURE OF [illegible]	
93. SIGNATURE OF [illegible]		94. SIGNATURE OF [illegible]	
95. SIGNATURE OF [illegible]		96. SIGNATURE OF [illegible]	
97. SIGNATURE OF [illegible]		98. SIGNATURE OF [illegible]	
99. SIGNATURE OF [illegible]		100. SIGNATURE OF [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

7071

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9 Film G244 7-1-59 et  
CERTIFICATE OF DEATH

07052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Choverly</b>				c. LENGTH OF STAY IN 1b <b>5 minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Margaret</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 22 / 1920</b>	
9. AGE (In years last birthday) <b>38 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>United States</b>	
13. FATHER'S NAME <b>James Brown</b>				14. MOTHER'S MAIDEN NAME <b>Emma Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Delores Brown Daughter Address same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia RLL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal failure.</b> DUE TO (c) <b>Carcinoma of the Cervix</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 20</b> , 19 <b>59</b> , to <b>June 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>59</b> , and that death occurred on <b>June 20</b> , 19 <b>59</b> , at <b>2:55 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius Kauffman</b>				ADDRESS (Street, city or town, state) <b>5102 Annap. Rd., Bladensburg Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. Kauffman</b>				DATE SIGNED <b>June 21 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>6-25-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S Washington</b>				ADDRESS <b>467 N at NW,</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 24 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 244 6-22-59 ams

07053

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington., D.C.</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>1032 3rd St. N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roscoe</b> Middle <b>Bush</b> Last <b>Bush</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 30 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>Washington D. C</b>
12. CITIZEN OF WHAT COUNTRY? <b>U/S.A.</b>			
13. FATHER'S NAME <b>Yates Bush</b>		14. MOTHER'S MAIDEN NAME <b>Florence Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Yates Bush, Father, 1709 New Jersey Ave. Wash. D.C.</b>		Address <b>D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heat Stroke</b> DUE TO <b>9318</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell unconscious while working on construction job</b>	
20c. TIME OF INJURY Month, Day, Year <b>3 (approx) 6-11-59</b> Hour <b>6:00 AM</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat white <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Construction job</b>		20f. (City or town) <b>Greenbelt</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>6/11</b> , 19 <b>59</b> , to <b>6/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/12</b> , 19 <b>59</b> , and that death occurred at <b>2:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur S. Kauffman</b>		DATE SIGNED <b>6/13/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. S. Kauffman., M.D.</b>		ADDRESS (Street, city or town, state) <b>5102 Arundel Rd. Beltsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington St. C.</b>		22d. LOCATION (City or town, or county) <b>D.C.</b> (State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gusch</b> ADDRESS <b>Sono Hyattsville Md</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kauffman</b> DATE <b>JUN 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kauffman</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

NAME OF DECEASED

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

OCCUPATION

DATE OF REPORT

BY

REPORTER

ADDRESS

CITY

STATE

COUNTY

TOWN

ZIP CODE

DATE OF REPORT

REPORTER

ADDRESS

CITY

STATE

COUNTY

TOWN

ZIP CODE

DATE OF REPORT

REPORTER

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

7122		Reg. Dist. No.	
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr 4 mos and 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 471-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 721 2nd St., N. E.	
3. NAME OF DECEASED (Type or print) First Middle Last Wilbur Carson		4. DATE OF DEATH Month Day Year 6 22 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Coppa Portra Mkt.,	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sam Carson		14. MOTHER'S MAIDEN NAME Elizabeth Conner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs., 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/30, 1958, to 6/22, 1959, that I last saw the deceased alive on 6/22/59, 19, and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 6/22/59 ACTUAL SIGNATURE Moe Weiss, M. D. PHYSICIAN'S NAME (Type) Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/59	
22c. NAME OF CEMETERY OR CREMATORY Wood Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart Funeral Home - 30th St NE		24a. REC'D BY REGISTRAR DATE JUN 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

7073

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>14 College Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Elvin</b> Middle <b>Fink</b> Last <b>Cartzendafner</b>			4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1922</b>	9. AGE (In years last birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Road equipment</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph R. Cartzendafner</b>			
14. MOTHER'S MAIDEN NAME <b>Lamora Fink</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth Cartzendafner; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 23, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Wheaton Md.</b>		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR <b>JUN 24 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>		DATE			

Name (Last, first, middle) <b>John A. Brown</b>		Sex <b>Male</b>		Age <b>35</b>		Date of Birth <b>May 10, 1902</b>		Place of Birth <b>St. Louis, Mo.</b>		Race <b>White</b>		Religion <b>Methodist</b>		Marital Status <b>Married</b>		Occupation <b>Engineer</b>		Cause of Death <b>Myocardial infarction</b>		Manner of Death <b>Natural</b>		Signature of Examiner <b>[Signature]</b>		Date <b>June 12, 1933</b>	
Residence <b>1234 Main St., Baltimore, Md.</b>		Usual Place of Work <b>City of Baltimore, Md.</b>		Usual Hours of Work <b>8:00 a.m. to 5:00 p.m.</b>		Usual Place of Recreation <b>Home</b>		Usual Companions <b>Family</b>		Usual Habits <b>None</b>		Usual Diet <b>Regular</b>		Usual Exercise <b>None</b>		Usual Temperance <b>None</b>		Usual Mental State <b>Normal</b>		Usual Physical State <b>Normal</b>		Usual Mental State <b>Normal</b>		Usual Physical State <b>Normal</b>	
History of Illness <b>None</b>		History of Trauma <b>None</b>		History of Alcoholism <b>None</b>		History of Drug Use <b>None</b>		History of Tobacco Use <b>None</b>		History of Venereal Disease <b>None</b>		History of Syphilis <b>None</b>		History of Tuberculosis <b>None</b>		History of Diabetes <b>None</b>		History of Hypertension <b>None</b>		History of Atherosclerosis <b>None</b>		History of Coronary Disease <b>None</b>		History of Myocardial Disease <b>None</b>	
History of Mental Disease <b>None</b>		History of Nervous System Disease <b>None</b>		History of Endocrine Disease <b>None</b>		History of Respiratory Disease <b>None</b>		History of Digestive Disease <b>None</b>		History of Urinary Disease <b>None</b>		History of Reproductive Disease <b>None</b>		History of Skin Disease <b>None</b>		History of Bone Disease <b>None</b>		History of Blood Disease <b>None</b>		History of Immune System Disease <b>None</b>		History of Infectious Disease <b>None</b>		History of Parasitic Disease <b>None</b>	
History of Allergic Disease <b>None</b>		History of Autoimmune Disease <b>None</b>		History of Genetic Disease <b>None</b>		History of Congenital Disease <b>None</b>		History of Acquired Disease <b>None</b>		History of Infectious Disease <b>None</b>		History of Parasitic Disease <b>None</b>		History of Immune System Disease <b>None</b>		History of Blood Disease <b>None</b>		History of Bone Disease <b>None</b>		History of Skin Disease <b>None</b>		History of Reproductive Disease <b>None</b>		History of Urinary Disease <b>None</b>	
History of Digestive Disease <b>None</b>		History of Respiratory Disease <b>None</b>		History of Endocrine Disease <b>None</b>		History of Nervous System Disease <b>None</b>		History of Mental Disease <b>None</b>		History of Infectious Disease <b>None</b>		History of Parasitic Disease <b>None</b>		History of Immune System Disease <b>None</b>		History of Blood Disease <b>None</b>		History of Bone Disease <b>None</b>		History of Skin Disease <b>None</b>		History of Reproductive Disease <b>None</b>		History of Urinary Disease <b>None</b>	
History of Allergic Disease <b>None</b>		History of Autoimmune Disease <b>None</b>		History of Genetic Disease <b>None</b>		History of Congenital Disease <b>None</b>		History of Acquired Disease <b>None</b>		History of Infectious Disease <b>None</b>		History of Parasitic Disease <b>None</b>		History of Immune System Disease <b>None</b>		History of Blood Disease <b>None</b>		History of Bone Disease <b>None</b>		History of Skin Disease <b>None</b>		History of Reproductive Disease <b>None</b>		History of Urinary Disease <b>None</b>	



FOR STATE  
HEALTH DEPT.

7074

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arden</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>/</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>McKinley</b> Last <b>Chaney</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April , 1902</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Chaney</b>		14. MOTHER'S MAIDEN NAME <b>Frances Crews</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>/</b>		16. SOCIAL SECURITY NO. <b>224-48-7376</b>	
17. INFORMANT <b>Geneva Thaxton, Vernon Hill, Virginia</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured skull plus other injuries, multi-</b> DUE TO (c) <b>ple and severe.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>/</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>A pedestrian, struck by an automobile on a highway.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>12.45</b> a. m. <b>6-8-</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Highway</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glen Arden</b>		20f. (City or town) <b>Pr. Geo.</b> (County) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 8, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Arden</b>		22d. LOCATION (City, town, or county) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stewart</b>		24a. REC'D BY REGISTRAR <b>June 10 '59</b>	
ADDRESS <b>30-H-st. N.E.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. K...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

7075  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
item 9 Film 6244 6-24-59 et  
CERTIFICATE OF DEATH

07057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>17</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		d. STREET ADDRESS <b>1108 Linden Ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>Anthony</b> Last <b>Cissel</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20 1905</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Harry Tyler Cissel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wicks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Harry A Cissel Son</b>	
17. INFORMANT <b>Address same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 1/2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of tongue</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1955</b> to <b>June 13 1959</b> , that I last saw the deceased alive on <b>June 13 1959</b> , and that death occurred at <b>3:57 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>L. Levitsky M.D.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>L. Levitsky M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried June 17-1959</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Talley</b>		ADDRESS <b>254 Carroll St.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1937

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1900	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		Jan 15, 1937		10:30 AM	
Occupation		Signature of Physician		Signature of Registrar		Signature of Coroner	
Teacher		[Signature]		[Signature]		[Signature]	
Residence		Hospital		City		State	
123 Main St		St. Mary's		Baltimore		Maryland	
Burial Place		Burial Date		Burial Time		Burial Place	
Catholic Cemetery		Jan 18, 1937		12:00 PM		Catholic Cemetery	
Funeral Home		Funeral Date		Funeral Time		Funeral Place	
Doe & Sons		Jan 20, 1937		10:00 AM		Catholic Cemetery	

RECEIVED  
JAN 16 1937  
BALTIMORE  
STATE DEPARTMENT OF HEALTH

7123

# CERTIFICATE OF DEATH

07058

Reg. Dist. No.

MEDICAL CERTIFICATION	1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews Air Force Base</b>		c. LENGTH OF STAY IN 1b <b>18 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews Air Force Base</b>	
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Building 100 Room 111</b>			d. STREET ADDRESS <b>Building 100 Room 111</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	3. NAME OF DECEASED (Type or print) <b>Herman</b> First <b>Elbert</b> Middle <b>Cole</b> Last			4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1959</b>		
	5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Jan 1912</b>	9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Airman USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAF</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
	13. FATHER'S NAME <b>Samuel Craten Cole</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Leather Wood</b>		
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes Jan 40-Jun 59</b>			16. SOCIAL SECURITY NO. <b>254-03-7309</b>		
	17. INFORMANT <b>Official USAF Service Records</b>			Address		
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) <b>Probable heart failure</b> DUE TO (c) <b>Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>Andrews</b>		20g. (County) <b>Prince Georges</b>		20h. (State) <b>MARYLAND</b>		
21. I certify that I attended the deceased from <b>9:40AM 1Jun, 1959</b> , to <b>9:40AM 1Jun, 1959</b> , that I last saw the deceased alive on <b>Never</b> , and that death occurred at <b>1:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Andrews AFB, Wash 25 D C</b> DATE SIGNED <b>1 June 1959</b> ACTUAL SIGNATURE <b>Richard H Weber</b> PHYSICIAN'S NAME (Type) <b>RICHARD H WEBER CAPT USAF MC</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>JUNE 4, 1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>VILLARICA</b> 22d. LOCATION (City, town, or country) (State) <b>GEORGIA</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>RINALDI FUNERAL HOME</b> ADDRESS <b>816 1/2 ST. NE. WASH. DC</b> 24a. REC'D BY REGISTRAR <b>JUN 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>						

VS A15 (4)  
15M 9/55





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7124

CERTIFICATE OF DEATH

07059

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR-Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28-RANDALL Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GENERAL</u> Middle <u>COONCE</u> Last <u>COONCE</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29-1900</u>		9. AGE (In years lost birthday) <u>58</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Washington Coonce</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA HICKHAM.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>OPAL N. COONCE</u>				Address <u>28-RANDALL Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>59</u> , to <u>June 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>59</u> , and that death occurred at <u>11:40</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.				ADDRESS (Street, city or town, state) <u>5440 Selver Hill Rd SE</u> DATE SIGNED <u>6-19-59</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>				<u>Washington 28</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-22-59</u>		<u>Cedar Hill</u>		<u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros. Funeral Home</u>				ADDRESS <u>1661 Good Hope Rd WASH. DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cirina S. Hana</u>			

1500

1500

1500

1500

1500

1500

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7125 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07060  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenridge</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5000 Surrey Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Lottie</b> Last <b>Cox</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert E. Nalley</b>		14. MOTHER'S MAIDEN NAME <b>Blanche E. Penn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mary Ellen Thompson; same address as # 2.</b>	
17. INFORMANT <b>Mary Ellen Thompson; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Toxemia</b> (a), stating the underlying cause last. DUE TO (c) <b>Infected decubital ulcers and gangrene of foot.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, diabetes.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 30, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home, Inc.</b>		ADDRESS <b>Mt. Rainier, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. ...</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
June 10, 1955		New York City		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
June 10, 1955		New York City		[Seal]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07061

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <b>Alexandria</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>			c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria 83x-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jones' Point Bridge</b>				d. STREET ADDRESS <b>3411 Richomnd Highway</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <b>Clyde Auburn Crawford</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>22</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 1, 1931</b>	
<b>9. AGE</b> (In years last birthday) <b>28 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>28</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bridge building</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Arkansas</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Prentis Crawford</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ada ?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> <b>Viola Irene Crawford</b>		<b>Address</b> <b>Same as # 2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a) Asphyxia</b>  <b>929.8 DUE TO</b>  <b>Conditions, if any, which gave rise to immediate cause (b) Drowning</b>  <b>(c), stating the underlying cause lost. DUE TO</b> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)</b> <b>Crushed chest, laceration and fracture of the right jaw</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Tank fell on him and forced him below the water</b>				<b>20c. TIME OF INJURY</b> Hour <b>12 Noon</b> a. m. <b>0</b> m. <b>0</b> s. <b>6/22/ 19 59</b>			
<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Jones Point</b>		<b>20f. (City or town)</b> <b>Potomac River</b>		<b>(County)</b> <b>P. G.</b>	
<b>20g. (State)</b> <b>Md.</b>		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined monner <input type="checkbox"/></b>					
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i>				<b>DATE SIGNED</b> <b>6/22/59</b>			
<b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>6/27/1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Garden of Memories Cem.</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Sikeston, Scott Co., Missouri</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Company, Riverdale, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 29 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7076

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07062

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>29 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>L</u> Middle <u>Creech</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
13. FATHER'S NAME <u>Calvin Jones</u>		14. MOTHER'S MAIDEN NAME <u>Zelphia Ann Creech - Mc</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Ken Bush</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>Liver failure, jaundice</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Carcinoma head of pancreas</u> DUE TO (b) <u>Carcinoma head of pancreas</u> DUE TO (c) <u>Carcinoma head of pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>59</u> , to <u>June 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rowland F. Wilkinson</u> M.D.		ADDRESS (Street, city or town, state) <u>4408 Queensbury Rd</u> DATE SIGNED <u>6/12/59</u>	
PHYSICIAN'S NAME (Type) <u>Rowland F. Wilkinson</u>		<u>Riverdale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Creech Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Mt. Olive, Duplin Co. N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Hume</u> 24b. REGISTRAR'S SIGNATURE	
DATE JUN 16 '59			

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1930-01-15</i></p>	
<p>5. PLACE OF BIRTH <i>New York, N.Y.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1955-06-10</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>1975-03-20</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>15. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>16. DATE OF CERTIFICATE <i>1975-03-25</i></p>	



This certificate is to be used for the purpose of recording the death of a person in the State of Maryland. It is to be filled out by the attending physician or the person in charge of the funeral home. The certificate is to be signed by the physician or the person in charge of the funeral home. The certificate is to be filed in the office of the Registrar of the State of Maryland.

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7051

CERTIFICATE OF DEATH

07063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>A. Cumberland</u> Last <u></u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-1869</u>		9. AGE (In years lost birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postoffice</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Cumberland</u>				14. MOTHER'S MAIDEN NAME <u>Mary Virginia Norris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>DC Nat'l Guard 1942-1945</u>				16. SOCIAL SECURITY NO. <u>578-2874-7A</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident.</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Degeneration</u> DUE TO <u>Arteriosclerotic Heart &amp; Vascular Disease</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 yrs</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>June 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>59</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon W. Kelley</u>				ADDRESS (Street, city or town, state) <u>6124-41st Ave Hyattsville Md</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>				DATE SIGNED <u>6/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 25, 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Haffel</u>				ADDRESS <u>475-H-38 10th 1086</u>		24a. REC'D BY REGISTRAR <u>JUN 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frazier</u>			

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



7127

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>301 UPPER MARLBORO</u>				c. LENGTH OF STAY IN 1b <u>48</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 301</u>			
d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CURTIS BERTHA EMMA CURTIS</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 5, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JAMES HOLLY</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE BRISCOE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>GLADYS ESTEP (DAUGHTER)</u> Address <u>UPPER MARLBORO, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INANITION</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>UREMIA</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u> <u>2 WKS</u> <u>3 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL VASCULAR ACCIDENT</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MARCH, 1956</u> , to <u>JUNE, 1959</u> , that I last saw the deceased alive on <u>JUNE 7, 1959</u> , and that death occurred at <u>9:00 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cherett W. Cadenhead</u>				ADDRESS (Street, city or town, state) <u>3904 ELN ST. UPPER MARLBORO</u>			
DATE SIGNED <u>—</u>				DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>MARYLAND</u>				PHYSICIAN'S NAME (Type) <u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.10.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. [Signature]</u>				ADDRESS <u>820 9th St., N.W.</u> <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>				24c. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7052

CERTIFICATE OF DEATH

07065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE Convalescent Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>NUTTALL</u> Last <u>Dobson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/21/75</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	9c. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	10c. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Blackpool, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u>	
13. FATHER'S NAME <u>John Dobson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son-in-law</u> Address <u>Walter R. Longenecker - 9052 R.I. C.P.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>332X</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>59</u> , to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		ADDRESS (Street, city or town, state) <u>4713 - Benjamin Rd College Park, Md</u> DATE SIGNED <u>6/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Alexandria Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07066

7077

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>821 51st Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Donn</b> Last <b>Donn</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8/</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/86</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Ward</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hooper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Cheverly, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Heart Disease</b> DUE TO <b>Hypertension</b> (c) <b>Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6</b> , 19 <b>59</b> to <b>June 8</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 8</b> , 19 <b>59</b> , and that death occurred at <b>8:55 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Til Bergman</b>		ADDRESS (Street, city or town, state) <b>4314 Falls Cr. Rd.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>		DATE SIGNED <b>June 8 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/59</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Glenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Casch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	

THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6244 7-15-59 et

07067

7078

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>3hrs 15min 33</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>4618 Annapolis Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Drake</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17 - 1905</b>		9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Swanee Drake</b> Address <b>4618 Annapolis Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>Acute pulmonary congestive edema</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis to heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 28</b> , 19 <b>59</b> , to <b>June 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>6:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius J. Kauffman</b> M.D.		ADDRESS (Street, city or town, state) <b>5702 Annapolis Rd. Bladensburg, Md.</b>		DATE SIGNED <b>6/29/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. Kauffman M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>7-2-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>H. 11 - Benning Rd. N.E.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Wachsmuth</b> ADDRESS <b>467 N st NW</b>				24a. REC'D BY REGISTRAR <b>JUL 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Knecht</b>	

2

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7128

CERTIFICATE OF DEATH

07068

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AFB WASH 25, D.C.</u><br>c. LENGTH OF STAY IN 1b <u>37 HOURS</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>usaf Hospital Andrews</u> |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u><br>d. STREET ADDRESS <u>2601 Rochelle</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>INFANT MALE DUMONT</u>   |  | 4. DATE OF DEATH Month Day Year <u>JUNE 13 1959</u>   |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>cau</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>11 June 59</u>   |
| 9. AGE (In years lost birthday) <u>—</u> yrs.   |  | IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>  | IF UNDER 24 HRS. Mins. <u>13</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                      |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 13. FATHER'S NAME <u>Douglas Dumont</u>   |  |
| 14. MOTHER'S MAIDEN NAME <u>Bamb. Hendrick</u>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>   |  |
| 16. SOCIAL SECURITY NO. <u>N/A</u>  |  | 17. INFORMANT <u>Douglas Dumont</u> Address <u></u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>776X Prematurity</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u><br>DUE TO (c) <u></u>                           |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>37 HOURS</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>13 June</u> , 19 <u>59</u> , to <u>13 June</u> , 19 <u>59</u> . That I last saw the deceased alive on <u>13 June</u> , 19 <u>59</u> , and that death occurred at <u>0210A</u> M, from the causes and on the date stated above.   |  |   |  |
| ACTUAL SIGNATURE <u>Reginald P. McManus</u> M.D.  |  | ADDRESS (Street, city or town, state) DATE SIGNED <u>13 JUNE 1959</u>   |  |
| PHYSICIAN'S NAME (Type) <u>REGINALD P. McMANUS, CAPT, USAF(MC) USAF HOSPITAL ANDREWS WASH 25, D.C.</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>  | 22b. DATE THEREOF <u>6-16-59</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>LEE CREMATORY</u>   | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u> ADDRESS <u>816 N St. N.E. DC</u>   |  | 24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |

2050288XVO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7079

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07069

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>        |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chesley</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>10 hours</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hillcrest Heights</b> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>2332 Kenton Pl.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby Girl</b> Middle <b>Edstrom</b> Last  |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>22</b> Year <b>19 59</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 22 1959</b>   |  |
| 9. AGE (In years last birthday)<br><b>10</b>  |  | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>United States</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Edward Edstrom</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Constance</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)<br><b>Constance</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Mother</b>   |  |   |  |
| 17. INFORMANT<br><b>Address same</b>  |  |   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis, Congenital</b><br><b>762.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b><br>DUE TO (c) |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. <b>19</b> Month, Day, Year<br>p. m.   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)<br><b>Hazleton Pa.</b>  |  |   |  | (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>June 22</b> , 19 <b>59</b> , to <b>June 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>59</b> , and that death occurred at <b>6:00P</b> M, from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Harry E. Oltman</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>6124 Central Ave. Cap. Hts. Md.</b>   |  |   |  |
| DATE SIGNED <b>6/23/59</b>  |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type)   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>June 24, 1959</b>                               |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fountain Hill</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hazleton Pa.</b>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lee Funeral Home - Washington, D.C.</b>  |  |   |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 25 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 2 Film 6244 7-7-59 et  
7129  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

07070

Reg. Dist. No.

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Ohio Maryland</b><br>b. COUNTY<br><b>Pr./Geo.?</b> |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ardmore</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ardmore Millersburg 72x-3</b>                                       |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Marine Home for Retarded Children</b>   |                                  | d. STREET ADDRESS<br><b>Marine Home ?? for Retarded Children</b>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Thomas Joel Everhart</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 24 1959</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>4-21-1951</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>8</b>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>*****</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Ray Everhart</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Elizabeth Hinegardner</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Records of Marine Home.</b>  |                                      |
| 17. INFORMANT<br><b>Records of Marine Home.</b>  |                                  | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Exhaustion</b><br><b>325.4</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Mongolism</b><br>DUE TO<br>(c)  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>May</b> , 19 <b>54</b> , to <b>June 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 23</b> , 19 <b>59</b> , and that death occurred at <b>6.00 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>John T. Maloney</b> M.D.<br>John T. Maloney, M.D. Box 357 Hattsville, Maryland |                                  |  |                                      |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>6-26-59</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James T. Ryan, Inc.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>JUN 29 59</b>  |                                      |
| ADDRESS<br><b>317 Penna. Ave., SE</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Carl L. Kross</b>   |                                      |

100



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07071

Reg. Dist. No.

7053

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>   |   |
| c. LENGTH OF STAY in 1b <u>50 yrs</u>  |   | d. STREET ADDRESS <u>14921-40th Place</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4921-40th Place</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Pearl</u> Middle <u>Cecilia</u> Last <u>Fennick</u>  |   | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>13</u> Year <u>1959</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-2-67</u>                                       |
| 9. AGE (in years last birthday) <u>91</u> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME <u>William Wallace Whelock</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Rachel Ann Robinson</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>Manon G. Fennick, as #3</u>   |   |
| 17. INFORMANT <u>Manon G. Fennick, as #3</u>   |   | Address <u>Same address</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4200 Exhaustion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Semibility</u> |   |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <u>19</u> a. m. <u>19</u> p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .                                      |   |  |   |
| ACTUAL SIGNATURE <u>John J. Maloney</u>  |   | DATE SIGNED  |   |
| EXAMINER'S NAME (Type) <u>JOHN T. MALONEY</u>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
|  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-14-1959</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>6/16/59</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>  |   | ADDRESS <u>Hyattsville, Maryland.</u>  |   |
| 24a. REC'D BY REGISTRAR <u>JUN 17 '59</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>  |   |

MEDICAL CERTIFICATION

10

FOR STATE  
HEALTH DEPT.

7080

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07072

Reg. Dist. No.

|  |                                 |   |  |
|--|---------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                                 | c. LENGTH OF STAY IN 1b <b>D.O.A.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>  |                                 | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Frank Miller Flanagan</b>  |                                 | 4. DATE OF DEATH Month Day Year<br><b>June 4, 19 59</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>white</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH <b>January 24, 1910 49</b>                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail clerk</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <b>Mail</b>   | 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>      |
| 13. FATHER'S NAME <b>William J.J. Flanagan</b>   |                                 | 14. MOTHER'S MAIDEN NAME <b>Lucy Miller</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                                 | 16. SOCIAL SECURITY NO. <b>Leila Ruth Flanagan; same address as</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] #2.  |                                 |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b><br>(a), stating the underlying cause lost. DUE TO (c)  |                                 |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |                                 | DATE SIGNED <b>June 4, 1959</b>   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>6/8/59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>  | 22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home, Inc.</b>  |                                 | 24a. REC'D BY REGISTRAR <b>DATE JUN 10 '59</b>  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                      |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STAMP  
HEALTH UNIT

1950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                               |  |                             |  |
|-------------------------------|--|-----------------------------|--|
| Name of Deceased              |  | John T. Blaney              |  |
| Sex                           |  | Male                        |  |
| Age                           |  | 45                          |  |
| Date of Birth                 |  | 1905                        |  |
| Place of Birth                |  | New York                    |  |
| Usual Residence               |  | New York                    |  |
| Cause of Death                |  | Acute myocardial infarction |  |
| Manner of Death               |  | Natural                     |  |
| Signature of Medical Examiner |  | [Signature]                 |  |
| Date                          |  | 1950                        |  |
| Place                         |  | New York                    |  |
| Signature of Coroner          |  | [Signature]                 |  |
| Date                          |  | 1950                        |  |
| Place                         |  | New York                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07073

7130

# CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |  |   |   |  |
|--|---|---|---|--|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>  |   |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>NEW JERSEY</b> b. COUNTY <b>HUDSON</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANDREWS AFB</b>   |   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION CITY</b> <b>67x-3</b>                                    |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>USAF HOSPITAL ANDREWS</b>   |   |   |   | d. STREET ADDRESS<br><b>153-49TH STREET</b>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First <b>JAMES</b> Middle <b>JOSEPH</b> Last <b>FLYNN</b>  |   |   |   | <b>4. DATE OF DEATH</b><br>Month <b>JUNE</b> Day <b>9</b> Year <b>1959</b>   |   |   |  |
| <b>5. SEX</b><br><b>MALE</b>   | <b>6. COLOR OR RACE</b><br><b>CAUCASION</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>29 APRIL 1938</b> |  | <b>9. AGE</b> (In years lost birthday) <b>21</b> yrs. | <b>IF UNDER 1 YEAR</b><br>Months <b>21</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> | <b>IF UNDER 24 HRS.</b><br>Hours <b>0</b> Min. <b>0</b>  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>USAF AIRMAN</b>   |   |   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>WEATHER OBSERVER</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>JERSEY CITY, NEW JERSEY</b>    |  |
| <b>13. FATHER'S NAME</b><br><b>JAMES JOSEPH FLYNN</b>  |   |   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>MARIE SCHIERECK</b>  |   |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>NA</b>   |   | <b>16. SOCIAL SECURITY NO.</b><br><b>145-28-6619</b>  |   | <b>17. INFORMANT</b><br><b>MARIE C. FLYNN (MOTHER)</b>   |   | Address <b>6102-PARK AVENUE W. NEW YORK, N.J.</b>                                     |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b><br><b>200.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RETICULUM CELL SARCOMA</b><br>DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b><br><b>6 MONTHS</b> |   |   |   |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |   |   |   |  |   |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> _____ (County) _____ (State) _____                         |  |
| <b>21. I certify that I attended the deceased from</b> <b>28 MAY</b> , 19 <b>59</b> , to <b>9 JUNE</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9 JUNE</b> , 19 <b>59</b> , and that death occurred at <b>12:55 P</b> M, from the causes and on the date stated above.  |   |   |   |  |   |   |  |
| <b>ACTUAL SIGNATURE</b> <b>William S. Vaun</b> M.D.  |   |   |   | <b>ADDRESS</b> (Street, city or town, state) <b>USAF HOSP ANDREWS</b> <b>DATE SIGNED</b> <b>9 JUNE 1959</b>  |   |   |  |
| <b>PHYSICIAN'S NAME (Type)</b> <b>WILLIAM S. VAUN CAPT USAF MC</b>   |   |   |   | <b>WASHINGTON 25, D.C.</b>   |   |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial-transit 6-12-59</b>  |   | <b>22b. DATE THEREOF</b><br><b>6-12-59</b>  |   | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Madonna Cemetery</b>   |   | <b>22d. LOCATION (City, town, or county)</b> (State) <b>Ft. Lee, New Jersey.</b>      |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>ROBERT A. PUMPHREY</b>   |   |   |   | <b>ADDRESS</b><br><b>Bethesda, Md.</b>   |   | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE JUN 12 '59</b>                              |  |
|  |   |   |   |  |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Harris</b>                          |  |

CERTIFICATE OF DEATH

7130

Page 1 of 1

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>JAMES J. HENRY     |  | 2. SEX<br>Male                            |  | 3. AGE<br>65                             |  | 4. DATE OF BIRTH<br>1885                 |  | 5. PLACE OF BIRTH<br>New York             |  |
| 6. OCCUPATION<br>Teacher                  |  | 7. CAUSE OF DEATH<br>Heart Disease        |  | 8. MANNER OF DEATH<br>Natural            |  | 9. PLACE OF DEATH<br>Home                |  | 10. DATE OF DEATH<br>1950                 |  |
| 11. SIGNATURE OF PHYSICIAN<br>J. H. Smith |  | 12. SIGNATURE OF REGISTRAR<br>J. H. Smith |  | 13. SIGNATURE OF DECEASED<br>J. H. Smith |  | 14. SIGNATURE OF WITNESS<br>J. H. Smith  |  | 15. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 16. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 17. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 18. SIGNATURE OF DECEASED<br>J. H. Smith |  | 19. SIGNATURE OF DECEASED<br>J. H. Smith |  | 20. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 21. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 22. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 23. SIGNATURE OF DECEASED<br>J. H. Smith |  | 24. SIGNATURE OF DECEASED<br>J. H. Smith |  | 25. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 26. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 27. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 28. SIGNATURE OF DECEASED<br>J. H. Smith |  | 29. SIGNATURE OF DECEASED<br>J. H. Smith |  | 30. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 31. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 32. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 33. SIGNATURE OF DECEASED<br>J. H. Smith |  | 34. SIGNATURE OF DECEASED<br>J. H. Smith |  | 35. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 36. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 37. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 38. SIGNATURE OF DECEASED<br>J. H. Smith |  | 39. SIGNATURE OF DECEASED<br>J. H. Smith |  | 40. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 41. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 42. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 43. SIGNATURE OF DECEASED<br>J. H. Smith |  | 44. SIGNATURE OF DECEASED<br>J. H. Smith |  | 45. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 46. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 47. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 48. SIGNATURE OF DECEASED<br>J. H. Smith |  | 49. SIGNATURE OF DECEASED<br>J. H. Smith |  | 50. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 51. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 52. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 53. SIGNATURE OF DECEASED<br>J. H. Smith |  | 54. SIGNATURE OF DECEASED<br>J. H. Smith |  | 55. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 56. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 57. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 58. SIGNATURE OF DECEASED<br>J. H. Smith |  | 59. SIGNATURE OF DECEASED<br>J. H. Smith |  | 60. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 61. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 62. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 63. SIGNATURE OF DECEASED<br>J. H. Smith |  | 64. SIGNATURE OF DECEASED<br>J. H. Smith |  | 65. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 66. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 67. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 68. SIGNATURE OF DECEASED<br>J. H. Smith |  | 69. SIGNATURE OF DECEASED<br>J. H. Smith |  | 70. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 71. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 72. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 73. SIGNATURE OF DECEASED<br>J. H. Smith |  | 74. SIGNATURE OF DECEASED<br>J. H. Smith |  | 75. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 76. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 77. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 78. SIGNATURE OF DECEASED<br>J. H. Smith |  | 79. SIGNATURE OF DECEASED<br>J. H. Smith |  | 80. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 81. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 82. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 83. SIGNATURE OF DECEASED<br>J. H. Smith |  | 84. SIGNATURE OF DECEASED<br>J. H. Smith |  | 85. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 86. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 87. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 88. SIGNATURE OF DECEASED<br>J. H. Smith |  | 89. SIGNATURE OF DECEASED<br>J. H. Smith |  | 90. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 91. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 92. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 93. SIGNATURE OF DECEASED<br>J. H. Smith |  | 94. SIGNATURE OF DECEASED<br>J. H. Smith |  | 95. SIGNATURE OF DECEASED<br>J. H. Smith  |  |
| 96. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 97. SIGNATURE OF DECEASED<br>J. H. Smith  |  | 98. SIGNATURE OF DECEASED<br>J. H. Smith |  | 99. SIGNATURE OF DECEASED<br>J. H. Smith |  | 100. SIGNATURE OF DECEASED<br>J. H. Smith |  |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18



## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGE</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> 15 X-2  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>CATTON MANOR - 4932 LASALLE RD.</b>  |                                  | d. STREET ADDRESS<br><b>4807 NAMPDEN LANE</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HETTIE</b> Middle <b>Elizabeth</b> Last <b>FRANKS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>12</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-13-99</b>   |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALES LADY</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>LOUISIANA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>David Moise</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Cora Washington</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address<br><b>Sister M. Joseph Bernadette O'Neil</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Depression</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident (Hypertension)</b><br>DUE TO (c) <b>Hypertension + arteriosclerosis</b>   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>1 day</b><br><b>years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |
| 20f. (City or town) (County) (State)  |                                  | 20g. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>6/4/59</b> , 19 <b>59</b> , to <b>6/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/11/59</b> , 19 <b>59</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4323 Harvard St. Silver Spring</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Richard P. Delaney</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>RICHARD P. DELANEY, M.D.</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>6-15-59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Congressional Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                  | ADDRESS<br><b>Bethesda, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 15 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



7131

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>        |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Temple Hills</u>  |  | c. LENGTH OF STAY IN 1b<br><u>15 years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Temple Hills</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>5218 Fisher Road</u>  |  |   |  | e. STREET ADDRESS<br><u>15218 Fisher Road</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Arthur</u> Middle <u>Elias</u> Last <u>Gray</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>11</u> Year <u>1959</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Jan 4, 1900</u>  |  |
| 9. AGE (in years last birthday)<br><u>59</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Service Man</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Washita Post Office</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><u>Elias Columbus Gray</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Emma Anderson</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>577-07-7761</u>  |  | 17. INFORMANT<br><u>John Gray, 5806 30th Avenue Hyattsville Md</u>                                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiorenal disease</u><br>DUE TO (c) <u>  </u>  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |  | 20f. (City or town) (County) (State)<br><u>  </u>   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>James I. Boyd</u>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <u>James I. Boyd</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 11, 1959</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>June 13-59</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Southard Md.</u>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Simmons Brothers</u>  |  |   |  | ADDRESS<br><u>1661-94 Hope Rd SE</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUN 12 '59</u>   |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u>  |  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

7131

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

NAME OF DECEASED: [illegible]  
AGE: [illegible] SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7081

CERTIFICATE OF DEATH

07076

Reg. Dist. No.

|   |   |   |                                 |   |   |   |   |
|---|---|---|---------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges County</b> MARYLAND  |   |   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |   |   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>  |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>   |   |   |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Catherine</b> Middle <b>Roe</b> Last <b>Green</b>   |   |   |                                 | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>2</b> Year <b>19 59</b>  |   |   |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>10 7/04</b> | 9. AGE (In years last birthday) <b>54</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |                                 | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |   |
| 13. FATHER'S NAME <b>Winfield Roe</b>   |   |   |                                 | 14. MOTHER'S MAIDEN NAME <b>Evelyn Start</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>None</b>   |                                 | 17. INFORMANT <b>Walter Green</b>   |   | Address <b>Same as # 2</b>                    |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Thyroid gland</b><br>DUE TO <b>6 months</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 weeks</b><br>DUE TO (c) |   |   |                                 |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |                                 |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                 |   |   |   |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)             | (County)  | (State)                                   |   |   |
| 21. I certify that I attended the deceased from <b>May 15th</b> , 19 <b>59</b> , to <b>June 2nd</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 2nd</b> , 19 <b>59</b> , and that death occurred at <b>7P</b> M, from the causes and on the date stated above.   |   |   |                                 |   |   |   |   |
| ACTUAL SIGNATURE <b>J. H. Berger, M.D.</b>  |   |   |                                 | ADDRESS (Street, city or town, state) <b>4314 Falls Church Rd Hyattsville Md.</b>   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>May Lane</b>   |   |   |                                 |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>6/5/59</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>   |                                 | 22d. LOCATION (City, town, or county) <b>Colmar Manor,</b>  |   | (State) <b>Md.</b>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>   |   |   |                                 | ADDRESS <b>Hyattsville, Maryland</b>  |   | 24a. REC'D BY REGISTRAR <b>DATE JUN 8 '59</b> | 24b. REGISTRAR'S SIGNATURE <b>Cabing S. Evans</b>                                   |

CERTIFICATE OF DEATH

115076

Page 1 of 1

|                        |  |               |  |      |  |       |  |                |  |            |  |                |  |                |  |               |  |               |  |                        |  |                        |  |
|------------------------|--|---------------|--|------|--|-------|--|----------------|--|------------|--|----------------|--|----------------|--|---------------|--|---------------|--|------------------------|--|------------------------|--|
| Name of Deceased       |  | Date of Birth |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| John Doe               |  | 1/1/1900      |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |
| Place of Birth         |  | Date of Death |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| New York City          |  | 1/15/1950     |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |
| Age at Death           |  | Date of Death |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| 50 years               |  | 1/15/1950     |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |
| Date of Death          |  | Date of Death |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| 1/15/1950              |  | 1/15/1950     |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |
| Time of Death          |  | Date of Death |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| 10:00 AM               |  | 1/15/1950     |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |
| Signature of Physician |  | Date of Death |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| J. Doe, M.D.           |  | 1/15/1950     |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |
| Signature of Registrar |  | Date of Death |  | Sex  |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  |
| J. Doe, M.D.           |  | 1/15/1950     |  | Male |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1/15/1950     |  | 10:00 AM      |  | J. Doe, M.D.           |  | J. Doe, M.D.           |  |

1

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

7082

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

# CERTIFICATE OF DEATH

07077

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>11 1/2 hours</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joyce</b> Middle <b>Green</b> Last <b>Green</b>   |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>22</b> Year <b>19 59</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/29/59</b>                           |
| 9. AGE (In years lost birthday)<br><b>12</b> yrs.   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |                                  | 13. FATHER'S NAME<br><b>Sylvester George Greene</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Carolyn Grace Pauls</b>  |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>(If yes, give war or dates of service)</b>                                      |  |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT<br><b>Carolyn Mother address same</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute dehydration</b><br>DUE TO <b>Diarrhea</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diarrhea</b><br>DUE TO <b>Diarrhea</b><br>(c) <b>Diarrhea</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>3 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 22, 1959</b> , to <b>June 22, 1959</b> , that I last saw the deceased alive on <b>June 22, 1959</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE<br><b>Dr. B Van Gilder M.D.</b>  |                                  | DATE SIGNED<br><b>June 23, 1959</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>7-1-59</b>  |                                  | 22b. DATE THEREOF  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Prince George's General Hosp. Cheverly, Md.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harry W. Penn, Jr.</b>   |                                  | 24. REGISTRY REGISTRAR<br><b>DATE JUL 8 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knap</b>   |                                  | 24c. REGISTRAR'S SIGNATURE   |  |

2077183XV3



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07078

7132

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glass Manor</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5002 Leverett St</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X G LASSMANOR MD.</u><br>d. STREET ADDRESS <u>5002 LEVERETT ST.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>BERTHA</u> First <u>GROSSMAN</u> Middle <u>GROSSMAN</u> Last<br>5. SEX <u>7</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1886</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. <u>1959</u> |  | <b>4. DATE OF DEATH</b> <u>JUNE 30</u> 19 <u>59</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |  |  |  |
| 13. FATHER'S NAME <u>SAM</u> 14. MOTHER'S MAIDEN NAME <u>BERTHA GROSS</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Leon Grossman</u> Address  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR HEMORRHAGE</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u><br><u>Year</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <u>June 29</u> , 19 <u>59</u> , to <u>June 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>59</u> , and that death occurred at <u>7:40 M.</u> from the causes and on the date stated above.<br>ACTUAL SIGNATURE <u>Herbert Wisotsky</u> M.D. <u>101 Audley Lane</u> DATE SIGNED <u>6/30/59</u><br>PHYSICIAN'S NAME (Type) <u>HERBERT WISOTSKY MD</u> <u>Oxon Hill Md.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-1-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u> 22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Md</u>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewison</u> ADDRESS <u>2100 Eutaw Pl</u> 24a. REC'D BY REGISTRAR <u>JUL 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>   |  |  |  |



FOR STATE  
HEALTH DEPT.

7083

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07079

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hosp.</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Beatrice</b> Middle <b>Theresa</b> Last <b>Grove</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>8</b> Year <b>19 59</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-19-1893</b>                                |  |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>0</b>  |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>John C. Collins</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br><b>9739 53rd Avenue Paul Grove, College Park, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |  |   |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 9, 1959</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                        |  |
| <b>Burial</b>   |  | <b>6/11/59</b>  |  | <b>Fort Lincoln</b>  |  | <b>Colmar Manor, Md</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Malley's Funeral Home Inc.</b>   |  |   |  | ADDRESS <b>Mt. Rainier Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>JUN 12 '59</b>                         |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneiss</b>  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1005

WESTMANS STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

1-1-11

John U. Collins

1139 Third Avenue  
New York, N.Y.

Cause of Death: \_\_\_\_\_

Immediate Cause of Death: \_\_\_\_\_

John U. Collins, 1139 Third Avenue, New York, N.Y.



## 7133 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Pr. George</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u>                    |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Seat Pleasant</u>  |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>502-68th St.</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Marie</u> Middle <u>Margaret</u> Last <u>Guntow</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>21</u> Year <u>1959</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9/24/1910</u>  |  |
| 9. AGE (In years last birthday) yrs.<br><u>48</u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Telephone Supervisor</u> |  | 11. BIRTH PLACE (State or foreign country)<br><u>Wash., D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                 |  |
| 13. FATHER'S NAME<br><u>Albert L. Clarke</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Katherine Dalton</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><u>578-26-5896</u>  |  | 17. INFORMANT<br><u>Elia Sanford</u> Address <u>6510 C St., Md. Park, Md.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sarcoma of left &amp; right femur &amp; ilium</u><br>196.9 DUE TO <u>10 months</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 months</u><br>DUE TO (c) |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
| 20f. (City or town) (County) (State)  |  |   |  | 20g. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>June 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                     |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>J. Chester Brady</u> M.D.   |  |   |  | PHYSICIAN'S NAME (Type) <u>J. Chester Brady, M.D.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  |   |  | 22b. DATE THEREOF<br><u>6/25/59</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>                       |  |
| 22d. LOCATION (City, town, or county) (State)<br><u>Suitland, Md.</u>   |  |   |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers Co.</u> ADDRESS <u>517-11th St. SE, Wash., D.C.</u>  |  |   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>JUN 23 '59</u>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                          |  |                  |  |             |  |                  |  |                  |  |                   |  |                   |  |                               |  |                            |  |                            |  |
|--------------------------|--|------------------|--|-------------|--|------------------|--|------------------|--|-------------------|--|-------------------|--|-------------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased      |  | 2. Sex           |  | 3. Age      |  | 4. Date of death |  | 5. Time of death |  | 6. Place of death |  | 7. Cause of death |  | 8. Manner of death            |  | 9. Signature of physician  |  | 10. Signature of registrar |  |
| John Doe                 |  | Male             |  | 45          |  | 1910             |  | 10:00 AM         |  | New York City     |  | Heart Disease     |  | Natural                       |  | [Signature]                |  | [Signature]                |  |
| 11. Name of informant    |  | 12. Relationship |  | 13. Address |  | 14. City         |  | 15. State        |  | 16. County        |  | 17. District      |  | 18. Sub-district              |  | 19. Signature of informant |  | 20. Signature of registrar |  |
| Jane Doe                 |  | Wife             |  | 123 Main St |  | New York         |  | NY               |  | New York          |  | New York          |  | New York                      |  | [Signature]                |  | [Signature]                |  |
| 21. Name of funeral home |  | 22. Address      |  | 23. City    |  | 24. State        |  | 25. County       |  | 26. District      |  | 27. Sub-district  |  | 28. Signature of funeral home |  | 29. Signature of registrar |  | 30. Signature of registrar |  |
| Funeral Home             |  | 123 Main St      |  | New York    |  | NY               |  | New York         |  | New York          |  | New York          |  | [Signature]                   |  | [Signature]                |  | [Signature]                |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07081

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MA RYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>        |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>T.B.</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>Transient</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BRANDYWINE</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Debson Clinic</b>  |  |  |  | d. STREET ADDRESS<br><b>BOX 194 Route #3</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROSIE</b> Middle <b>LUCILLE</b> Last <b>HALL</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>29th</b> Year <b>19 59</b>  |  |   |   |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>NEGRO</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>UNK</b>  |   |
| 9. AGE (In years last birthday)<br><b>31</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b>   |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during past working life, even if retired)<br><b>DOMESTIC</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPLOYED</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  |  |  |  |   |   |
| 13. FATHER'S NAME<br><b>ARTHUR HALL</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH MEADE</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>597-42-5828</b>  |  | 17. INFORMANT<br>Address <b>ARTHUR HALL ROUTE #1 BRANDYWINE MD.</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage and Shock</b><br><b>981X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gun shot wound of abdomen</b><br>DUE TO (c) <b></b>  |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot during altercation</b> |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Hour <b>3:30</b> o. m. <b>2000</b> Month, Day, Year <b>6/29 19 59</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 20f. (City or town) (County) (State)<br><b>Route # 2 Brandywine, Md.</b>                              |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>James I. Boyd</b>  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED<br><b>6/29/1959</b>   |   |
| EXAMINER'S NAME (Type)<br><b>James I. Boyd</b>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>7-2-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Thomas</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Agawasco, Md.</b>                                 |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The Hunt Funeral Home, Waldorf, Md.</b>  |  |  |  | ADDRESS<br><b></b>   |  | 24a. REC'D BY REGISTRAR<br><b>JUL 8 '59</b>   |   |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hunt</b>  |  |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
7132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



1

*[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]*

NAME OF DECEASED: \_\_\_\_\_  
AGE: \_\_\_\_\_  
SEX: \_\_\_\_\_  
RACE: \_\_\_\_\_  
DATE OF DEATH: \_\_\_\_\_  
PLACE OF DEATH: \_\_\_\_\_  
CAUSE OF DEATH: \_\_\_\_\_  
MANNER OF DEATH: \_\_\_\_\_  
SIGNATURE OF EXAMINER: \_\_\_\_\_  
DATE: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7084

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07082

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |                                    |   |  |   |   |  |   |
|--|------------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince Georges</b> MARYLAND  |                                    |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jefferson Heights</b>                                      |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |                                    |   |  | d. STREET ADDRESS<br><b>1012 65th Place, N.E.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Clarence</b> Middle <b>Frederick</b> Last <b>Hammond</b>   |                                    |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7,</b> Year <b>19 59</b>   |   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 4, 1882</b> |   | 9. AGE (In years last birthday)<br><b>76</b> yrs. | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dining car waiter</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Clarence F. Hammond</b>  |                                    |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Beeks</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b><br>(If yes, give war or dates of service)  |                                    | 16. SOCIAL SECURITY NO.<br><b>719-07-0435</b>   |  | 17. INFORMANT<br><b>Clarence F. Hammond, Jr. same address as #2.</b><br>Address   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b><br>(a), stating the underlying cause lost. DUE TO (c)   |                                    |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |   |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |   |  |   |   |  |   |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |                                    |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED  |   |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |                                    |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                            |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 22b. DATE THEREOF<br><b>6 - 11 - 59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Carver Memorial</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Beltsville, Md.</b>                |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Myrtle E. Collins</b>   |                                    |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 12 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kraus</b>                                   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







CERTIFICATE OF DEATH

NAME OF DECEASED  
JAMES J. BROWN

|                         |  |                     |  |
|-------------------------|--|---------------------|--|
| 1. Name of deceased     |  | JAMES J. BROWN      |  |
| 2. Date of death        |  | JAN 12 1900         |  |
| 3. Place of death       |  | BALTIMORE, MARYLAND |  |
| 4. Cause of death       |  | DISEASE             |  |
| 5. Name of physician    |  | J. J. BROWN         |  |
| 6. Name of undertaker   |  | J. J. BROWN         |  |
| 7. Name of funeral home |  | J. J. BROWN         |  |
| 8. Name of cemetery     |  | J. J. BROWN         |  |
| 9. Name of church       |  | J. J. BROWN         |  |
| 10. Name of minister    |  | J. J. BROWN         |  |
| 11. Name of sexton      |  | J. J. BROWN         |  |
| 12. Name of registrar   |  | J. J. BROWN         |  |
| 13. Name of coroner     |  | J. J. BROWN         |  |
| 14. Name of jury        |  | J. J. BROWN         |  |
| 15. Name of witness     |  | J. J. BROWN         |  |
| 16. Name of witness     |  | J. J. BROWN         |  |
| 17. Name of witness     |  | J. J. BROWN         |  |
| 18. Name of witness     |  | J. J. BROWN         |  |
| 19. Name of witness     |  | J. J. BROWN         |  |
| 20. Name of witness     |  | J. J. BROWN         |  |
| 21. Name of witness     |  | J. J. BROWN         |  |
| 22. Name of witness     |  | J. J. BROWN         |  |
| 23. Name of witness     |  | J. J. BROWN         |  |
| 24. Name of witness     |  | J. J. BROWN         |  |
| 25. Name of witness     |  | J. J. BROWN         |  |
| 26. Name of witness     |  | J. J. BROWN         |  |
| 27. Name of witness     |  | J. J. BROWN         |  |
| 28. Name of witness     |  | J. J. BROWN         |  |
| 29. Name of witness     |  | J. J. BROWN         |  |
| 30. Name of witness     |  | J. J. BROWN         |  |
| 31. Name of witness     |  | J. J. BROWN         |  |
| 32. Name of witness     |  | J. J. BROWN         |  |
| 33. Name of witness     |  | J. J. BROWN         |  |
| 34. Name of witness     |  | J. J. BROWN         |  |
| 35. Name of witness     |  | J. J. BROWN         |  |
| 36. Name of witness     |  | J. J. BROWN         |  |
| 37. Name of witness     |  | J. J. BROWN         |  |
| 38. Name of witness     |  | J. J. BROWN         |  |
| 39. Name of witness     |  | J. J. BROWN         |  |
| 40. Name of witness     |  | J. J. BROWN         |  |
| 41. Name of witness     |  | J. J. BROWN         |  |
| 42. Name of witness     |  | J. J. BROWN         |  |
| 43. Name of witness     |  | J. J. BROWN         |  |
| 44. Name of witness     |  | J. J. BROWN         |  |
| 45. Name of witness     |  | J. J. BROWN         |  |
| 46. Name of witness     |  | J. J. BROWN         |  |
| 47. Name of witness     |  | J. J. BROWN         |  |
| 48. Name of witness     |  | J. J. BROWN         |  |
| 49. Name of witness     |  | J. J. BROWN         |  |
| 50. Name of witness     |  | J. J. BROWN         |  |
| 51. Name of witness     |  | J. J. BROWN         |  |
| 52. Name of witness     |  | J. J. BROWN         |  |
| 53. Name of witness     |  | J. J. BROWN         |  |
| 54. Name of witness     |  | J. J. BROWN         |  |
| 55. Name of witness     |  | J. J. BROWN         |  |
| 56. Name of witness     |  | J. J. BROWN         |  |
| 57. Name of witness     |  | J. J. BROWN         |  |
| 58. Name of witness     |  | J. J. BROWN         |  |
| 59. Name of witness     |  | J. J. BROWN         |  |
| 60. Name of witness     |  | J. J. BROWN         |  |
| 61. Name of witness     |  | J. J. BROWN         |  |
| 62. Name of witness     |  | J. J. BROWN         |  |
| 63. Name of witness     |  | J. J. BROWN         |  |
| 64. Name of witness     |  | J. J. BROWN         |  |
| 65. Name of witness     |  | J. J. BROWN         |  |
| 66. Name of witness     |  | J. J. BROWN         |  |
| 67. Name of witness     |  | J. J. BROWN         |  |
| 68. Name of witness     |  | J. J. BROWN         |  |
| 69. Name of witness     |  | J. J. BROWN         |  |
| 70. Name of witness     |  | J. J. BROWN         |  |
| 71. Name of witness     |  | J. J. BROWN         |  |
| 72. Name of witness     |  | J. J. BROWN         |  |
| 73. Name of witness     |  | J. J. BROWN         |  |
| 74. Name of witness     |  | J. J. BROWN         |  |
| 75. Name of witness     |  | J. J. BROWN         |  |
| 76. Name of witness     |  | J. J. BROWN         |  |
| 77. Name of witness     |  | J. J. BROWN         |  |
| 78. Name of witness     |  | J. J. BROWN         |  |
| 79. Name of witness     |  | J. J. BROWN         |  |
| 80. Name of witness     |  | J. J. BROWN         |  |
| 81. Name of witness     |  | J. J. BROWN         |  |
| 82. Name of witness     |  | J. J. BROWN         |  |
| 83. Name of witness     |  | J. J. BROWN         |  |
| 84. Name of witness     |  | J. J. BROWN         |  |
| 85. Name of witness     |  | J. J. BROWN         |  |
| 86. Name of witness     |  | J. J. BROWN         |  |
| 87. Name of witness     |  | J. J. BROWN         |  |
| 88. Name of witness     |  | J. J. BROWN         |  |
| 89. Name of witness     |  | J. J. BROWN         |  |
| 90. Name of witness     |  | J. J. BROWN         |  |
| 91. Name of witness     |  | J. J. BROWN         |  |
| 92. Name of witness     |  | J. J. BROWN         |  |
| 93. Name of witness     |  | J. J. BROWN         |  |
| 94. Name of witness     |  | J. J. BROWN         |  |
| 95. Name of witness     |  | J. J. BROWN         |  |
| 96. Name of witness     |  | J. J. BROWN         |  |
| 97. Name of witness     |  | J. J. BROWN         |  |
| 98. Name of witness     |  | J. J. BROWN         |  |
| 99. Name of witness     |  | J. J. BROWN         |  |
| 100. Name of witness    |  | J. J. BROWN         |  |

Reg. Dist. No.

VS. AISME  
5M 2/57

|   |                           |  |                                  |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince Georges  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Temple Hills  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Temple Hills   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>5056 Temple Hill Rd SE  |                           | e. STREET ADDRESS<br>5056 Temple Hill Rd SE  |                                  |
| 3. NAME OF DECEASED<br>(Type or print) Thomas Anthony Hanrahan  |                           | 4. DATE OF DEATH<br>Month June Day 17 Year 1959  |                                  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br>Sept 5, 1897 |
| 9. AGE (In years last birthday)<br>61 yrs.  |                           | 10. UNDER 1 YEAR<br>Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Cable Splices  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |                                  |
| 11. BIRTHPLACE (State or foreign country)<br>District of Columbia   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                  |
| 13. FATHER'S NAME<br>John Hanrahan  |                           | 14. MOTHER'S MAIDEN NAME<br>Unknown  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) No  |                           | 16. SOCIAL SECURITY NO.<br>577-01-2125   |                                  |
| 17. INFORMANT<br>Richard Hanrahan, 505- Butler Ave  |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 442X Acute congestive heart failure<br>DUE TO (b) Cardiovascular and related diseases<br>DUE TO (c) |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |                                  |
| ACTUAL SIGNATURE<br>James T. Boyd   |                           | DATE SIGNED<br>June 17, 1959   |                                  |
| EXAMINER'S NAME (Type)<br>James T. Boyd   |                           | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>6-20-59   |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Bnd.   |                           | 22d. LOCATION (City, town, or county) (State)<br>Wash. D. C.   |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>J. W. Lees, Jr.   |                           | ADDRESS<br>Wash. D. C.   |                                  |
| 24a. REC'D BY REGISTRAR<br>DATE JUN 22 '59  |                           | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Hines  |                                  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

7085 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07085

Reg. Dist. No.

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Florida</b> b. COUNTY <b>Leon</b>                             |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tallahassee</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>  |                               | d. STREET ADDRESS <b>2325 Perry Highway</b>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jonas</b> Middle <b>Elbert</b> Last <b>Harrell</b>   |                               | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>23</b> Year <b>19 59</b>  |                                    |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>           | 8. DATE OF BIRTH <b>12-15-1927</b> |
| 9. AGE (In years last birthday) <b>31</b> yrs.   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>  |                                    |
| 10b. KIND OF BUSINESS OR INDUSTRY  |                               | 11. BIRTHPLACE (State or foreign country) <b>Georgia</b>   |                                    |
| 13. FATHER'S NAME <b>Jonas Harrell</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Rosa Lee Thompson</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII-1948</b>  |                               | 17. INFORMANT Address <b>Betty Harrell; 309 South 4th Avenue Ann Arbor, Michigan</b>   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b><br>DUE TO <b>Fractured skull, legs and ribs.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Occupant of an automobile in collision with a bridge abutment.</b> |                                    |
| 20c. TIME OF INJURY Month, Day, Year <b>10-22-59</b> Hour <b>10:22</b> P.M.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>  |                               | 20f. (City or town) <b>Bowie</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>   |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                               |  |                                    |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                    |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                    |
|  |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 24, 1959</b>   |                                    |
| 22a. BURIAL, CREMATION, or other disposition <b>Transportation</b>   |                               | 22b. DATE THEREOF <b>6/26/59</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Colquitt</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Georgia</b>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch*s Sons</b>  |                               | ADDRESS <b>Hyattsville, Md.</b>  |                                    |
| 24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |                                    |

MEDICAL CERTIFICATION

099

I

16

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                       |  |                             |  |
|-----------------------|--|-----------------------------|--|
| Name of Deceased      |  | John J. Jones               |  |
| Sex                   |  | Male                        |  |
| Age                   |  | 35                          |  |
| Date of Birth         |  | 10-15-1897                  |  |
| Place of Birth        |  | Maryland                    |  |
| Usual Residence       |  | Room 100, Washington        |  |
| Cause of Death        |  | Sudden death, while working |  |
| Manner of Death       |  | Accident                    |  |
| Place of Death        |  | Room 100, Washington        |  |
| Date of Death         |  | June 28, 1932               |  |
| Time of Death         |  | 10:15 AM                    |  |
| Physician             |  | Dr. J. H. Smith             |  |
| Hospital              |  | None                        |  |
| Burial Place          |  | None                        |  |
| Burial Date           |  | None                        |  |
| Signature of Examiner |  | [Signature]                 |  |
| Date of Certificate   |  | June 28, 1932               |  |



7137 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE LEO. MARYLAND</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>PG</u>                             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>N.O. BRENTWOOD</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>34 BRENTWOOD</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS<br><u>13930 ALLISON ST.</u>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br><u>JOHN</u> First <u>WESLEY</u> Middle <u>HARRIS</u> Last  |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>11</u> Year <u>1959</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Col</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-5-1875</u>  |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NONE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>NEW YORK</u>  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><u>MOSE HARRIS</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><u>HELEN D. HARRIS-3930-ALLISON</u>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u><br>(c) <u>Arteriosclerosis</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>May 14 '59</u><br><u>10 yrs</u><br><u>10 yrs</u> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. <u>  </u> p. <u>  </u><br><u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I attended the deceased from <u>May 14, 1959</u> to <u>June 11, 1959</u> , that I last saw the deceased alive on <u>June 11, 1959</u> , and that death occurred at <u>5:44 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>509 R.I. Ave. N.W.</u> DATE SIGNED   |   |   |  |
| ACTUAL SIGNATURE<br><u>W.S. Hudson</u> M.D.   |   |   |  |
| PHYSICIAN'S NAME (Type)<br><u>W.S. HUDSON</u>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>6/16/59</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Lincoln Memorial</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Suitland, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John E. Howard</u>   |   | 24a. REC'D BY REGISTRAR<br><u>JUN 15 '59</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles E. Kraus</u>                      |
| 30 H Street, N.E.   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7086

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07087

Reg. Dist. No.

|   |                                  |   |                                      |  |   |  |                  |
|---|----------------------------------|---|--------------------------------------|--|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>  |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo</b> |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Clairview</b>                                       |   |  |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |                                  |   |                                      | d. STREET ADDRESS<br><b>6910 Marlboro Pike</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Allen</b> Middle <b>Stephenson</b> Last <b>Hartman</b>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>10</b> Year <b>19 59</b>  |   |  |                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-17-1900</b> |  | 9. AGE (In years last birthday)<br><b>58</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Butcher</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Meat</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                  |
| 13. FATHER'S NAME<br><b>Charles Hartman</b>   |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Estelle Hardesty</b>   |   |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>577-10-5238</b>   |                                      | 17. INFORMANT<br>Address<br><b>William H. Rutherford; same address as # 2.</b>   |   |  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heard failure</b><br><b>442X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |   |                                      |  |   |  |                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |  |                  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |                                  |   |                                      |  |   |  |                  |
| ACTUAL SIGNATURE <b>John J. Maloney</b>   |                                  |   |                                      | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED  |                  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>   |                                  |   |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |                  |
|   |                                  |   |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | <b>June 11, 1959</b>   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>6-14-59</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Forestville, Md</b>                |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert H. Mattingly</b>  |                                  |   |                                      | ADDRESS<br><b>Wash 300</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 12 '59</b>                                      |                  |
|   |                                  |   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |   |  |                  |

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE OF

WEST VIRGINIA

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

EDUCATION

RELIGION

USUAL OCCUPATION

PRESENT OCCUPATION

PREVAILING DISEASE

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PREVAILING DISEASE

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

DATE OF EXAMINATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7138

Item 7 Film G244 6-22-59 et

CERTIFICATE OF DEATH

07088

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGES</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANDREWS AFB</b><br>c. LENGTH OF STAY IN 1b<br><b>44 DAYS</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>USAF HOSPITAL ANDREWS</b> |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>DISTRICT OF COLUMBIA</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON</b><br>d. STREET ADDRESS<br><b>2 CHESAPEAKE STREET S.W.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|--|--|--|--|

|   |                                 |  |   |
|---|---------------------------------|--|---|
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>AUGUSTA CAIN HARVELL</b>                      |                                 | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 14 1959</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>CAUC</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>OCT. 27 1899</b> |
| 9. AGE (In years lost birthday)<br><b>69 yrs.</b>   |                                 | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NORTH CAROLINA</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>AMERICAN</b>  |                                 | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Mary Cain</b>   |   |

|  |   |   |   |
|--|---|---|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) | 17. INFORMANT<br><b>Zannette Harvell Cullen</b><br>(daughter) | Address<br><b>Chesapeake St. Wash., D. C.</b> |
|--|---|---|---|

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>ARTERIOSCLEROSIS</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MONTHS</b><br><b>YEARS</b> |
|--|--|---|

|   |  |   |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|---|

|  |   |  |
|--|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |

|  |  |
|--|--|
| 21. I certify that I attended the deceased from <b>14 JUNE</b> , 19 <b>59</b> , to <b>14 JUNE</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>14 JUNE</b> , 19 <b>59</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>USAF HOSPITAL ANDREWS 14 JUNE 59</b> |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   | PHYSICIAN'S NAME (Type)<br><b>JOHN C. SMITH CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASHINGTON 25, DC</b> |

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 22b. DATE THEREOF<br><b>6/18/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Salisbury, No. Carolina</b> | 22d. LOCATION (City, town, or county) (State) |
|--|-------------------------------------|--|---|

|  |   |  |  |
|--|---|--|--|
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>[Signature]</i> | ADDRESS<br><b>Rinaldi Funeral Home 816 H St, NE, DC 2</b> | 24a. REC'D BY REGISTRAR<br>DATE<br><b>JUN 17 '59</b> | 24b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |
|--|---|--|--|

# CERTIFICATE OF DEATH

1138

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 10-1-54

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>MILLARD            |  | 2. PLACE OF BIRTH<br>NEW YORK             |  |
| 3. DATE OF BIRTH<br>JAN 15 1901           |  | 4. CITY OF BIRTH<br>NEW YORK              |  |
| 5. SEX<br>MALE                            |  | 6. RACE<br>WHITE                          |  |
| 7. OCCUPATION<br>LABORER                  |  | 8. MARITAL STATUS<br>MARRIED              |  |
| 9. DATE OF DEATH<br>JAN 15 1954           |  | 10. PLACE OF DEATH<br>BALTIMORE           |  |
| 11. CAUSE OF DEATH<br>HEART DISEASE       |  | 12. MANNER OF DEATH<br>NATURAL            |  |
| 13. SIGNATURE OF PHYSICIAN<br>J. H. SMITH |  | 14. SIGNATURE OF REGISTRAR<br>J. H. SMITH |  |
| 15. SIGNATURE OF DECEASED<br>MILLARD      |  | 16. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 17. SIGNATURE OF DECEASED<br>MILLARD      |  | 18. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 19. SIGNATURE OF DECEASED<br>MILLARD      |  | 20. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 21. SIGNATURE OF DECEASED<br>MILLARD      |  | 22. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 23. SIGNATURE OF DECEASED<br>MILLARD      |  | 24. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 25. SIGNATURE OF DECEASED<br>MILLARD      |  | 26. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 27. SIGNATURE OF DECEASED<br>MILLARD      |  | 28. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 29. SIGNATURE OF DECEASED<br>MILLARD      |  | 30. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 31. SIGNATURE OF DECEASED<br>MILLARD      |  | 32. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 33. SIGNATURE OF DECEASED<br>MILLARD      |  | 34. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 35. SIGNATURE OF DECEASED<br>MILLARD      |  | 36. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 37. SIGNATURE OF DECEASED<br>MILLARD      |  | 38. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 39. SIGNATURE OF DECEASED<br>MILLARD      |  | 40. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 41. SIGNATURE OF DECEASED<br>MILLARD      |  | 42. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 43. SIGNATURE OF DECEASED<br>MILLARD      |  | 44. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 45. SIGNATURE OF DECEASED<br>MILLARD      |  | 46. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 47. SIGNATURE OF DECEASED<br>MILLARD      |  | 48. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 49. SIGNATURE OF DECEASED<br>MILLARD      |  | 50. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 51. SIGNATURE OF DECEASED<br>MILLARD      |  | 52. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 53. SIGNATURE OF DECEASED<br>MILLARD      |  | 54. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 55. SIGNATURE OF DECEASED<br>MILLARD      |  | 56. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 57. SIGNATURE OF DECEASED<br>MILLARD      |  | 58. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 59. SIGNATURE OF DECEASED<br>MILLARD      |  | 60. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 61. SIGNATURE OF DECEASED<br>MILLARD      |  | 62. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 63. SIGNATURE OF DECEASED<br>MILLARD      |  | 64. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 65. SIGNATURE OF DECEASED<br>MILLARD      |  | 66. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 67. SIGNATURE OF DECEASED<br>MILLARD      |  | 68. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 69. SIGNATURE OF DECEASED<br>MILLARD      |  | 70. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 71. SIGNATURE OF DECEASED<br>MILLARD      |  | 72. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 73. SIGNATURE OF DECEASED<br>MILLARD      |  | 74. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 75. SIGNATURE OF DECEASED<br>MILLARD      |  | 76. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 77. SIGNATURE OF DECEASED<br>MILLARD      |  | 78. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 79. SIGNATURE OF DECEASED<br>MILLARD      |  | 80. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 81. SIGNATURE OF DECEASED<br>MILLARD      |  | 82. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 83. SIGNATURE OF DECEASED<br>MILLARD      |  | 84. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 85. SIGNATURE OF DECEASED<br>MILLARD      |  | 86. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 87. SIGNATURE OF DECEASED<br>MILLARD      |  | 88. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 89. SIGNATURE OF DECEASED<br>MILLARD      |  | 90. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 91. SIGNATURE OF DECEASED<br>MILLARD      |  | 92. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 93. SIGNATURE OF DECEASED<br>MILLARD      |  | 94. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 95. SIGNATURE OF DECEASED<br>MILLARD      |  | 96. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 97. SIGNATURE OF DECEASED<br>MILLARD      |  | 98. SIGNATURE OF WITNESS<br>J. H. SMITH   |  |
| 99. SIGNATURE OF DECEASED<br>MILLARD      |  | 100. SIGNATURE OF WITNESS<br>J. H. SMITH  |  |



## 7139 CERTIFICATE OF DEATH

07089

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>PRINCE GEORGES</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>NORTH WOODRIDGE</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>NORTH WOODRIDGE (AVONDALE)</b>                                       |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4506 - 24th Avenue</b>   |  |   |  | d. STREET ADDRESS<br><b>4506- 24th AVENUE</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ANNA</b> Middle <b>ROEDER</b> Last <b>HEIST</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>30</b> Year <b>1959</b>   |  |   |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5/2/1874</b>   |  |
| 9. AGE (In years lost birthday)<br><b>85</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENN.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>ISAAC S. ROEDER</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>SCHANTZ</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |   |  |
| 17. INFORMANT<br><b>LeROY HEIST</b>   |  |   |  | Address <b>4506-24th AVE NORTH WOODRIDGE, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, right lung</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Congestive Heart failure</b><br>DUE TO (c) <b>Degenerative cardio-vascular disease</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>6 months</b><br><b>2 years</b>          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Sept. 17,</b> 19 <b>52</b> , to <b>June 30,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>June 29,</b> 19 <b>59</b> , and that death occurred at <b>4:25 AM</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Herbert G. Brandes</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>400 W St., N.E. Wash., D.C.</b> DATE SIGNED <b>June 30, 1959</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Herbert G. Brandes, M.D.</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 22b. DATE THEREOF<br><b>7/2/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Evangelical Church</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Old Zionsville, Pennsylvania</b>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JUL 1 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-9

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

21-11-00

35

2000

1.

• • • • •

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7087

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07090

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |  |   |  | c. LENGTH OF STAY IN 1b <b>D.O.A.</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Neipold</b> Last <b>Howes</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>18</b> Year <b>19 59</b>   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>2-26-08</b>                                    |  |
| 9. AGE (In years last birthday) <b>51</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>51</b> Days <b>18</b> Hours <b>19</b> Min.                                   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Undertaker</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Funerals</b>                  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 13. FATHER'S NAME <b>Frank Howes</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Ella Neipold</b>                       |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |  | 16. SOCIAL SECURITY NO. <b>577-09-0693</b>  |  | 17. INFORMANT <b>Katherine Howes; same address as #2.</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic valvular heart disease</b><br>DUE TO (c) <b>Aortic insufficiency</b>   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour <b>a. m.</b> <b>19</b> Month, Day, Year  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.   |  |   |  | DATE SIGNED <b>June 19, 1959</b>  |  |  |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>6/22/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home, Inc.</b><br><b>Mrs. Rainier. Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>                  |  |

MEDICAL CERTIFICATION

2

702

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                        |  |                      |  |                      |  |                      |  |                      |  |
|------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED       |  | SEX                  |  | AGE                  |  | DATE OF BIRTH        |  | PLACE OF BIRTH       |  |
| John Doe               |  | Male                 |  | 45                   |  | Jan 15, 1900         |  | New York City        |  |
| RESIDENCE              |  | OCCUPATION           |  | CAUSE OF DEATH       |  | MANNER OF DEATH      |  | PLACE OF DEATH       |  |
| 123 Main St, Baltimore |  | Teacher              |  | Heart Disease        |  | Natural              |  | Home                 |  |
| DATE OF DEATH          |  | TIME OF DEATH        |  | HOURS OF DEATH       |  | MINUTES OF DEATH     |  | SECONDS OF DEATH     |  |
| Jan 20, 1945           |  | 10:30 AM             |  | 10                   |  | 30                   |  | 00                   |  |
| SIGNATURE OF EXAMINER  |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  | SIGNATURE OF WITNESS |  |
| [Signature]            |  | [Signature]          |  | [Signature]          |  | [Signature]          |  | [Signature]          |  |
| OFFICIAL SEAL          |  | OFFICIAL SEAL        |  | OFFICIAL SEAL        |  | OFFICIAL SEAL        |  | OFFICIAL SEAL        |  |
| [Seal]                 |  | [Seal]               |  | [Seal]               |  | [Seal]               |  | [Seal]               |  |

1  
 7140 Item 2 Film G246 7-31-59 et  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

08257

Reg. Dist. No.

|  |   |   |   |  |   |   |  |
|--|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGES</b> MARYLAND  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Tennessee</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> 79X-3 |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANDREWS AFB WASH 25 DC</b>  |   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON</b> <b>Lynnville</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>USAF HOSPITAL ANDREWS</b>   |   |   |   | d. STREET ADDRESS <b>Bldg. 829 Rt. 3, Box 7 Bolling AFB WASH 25 DC</b>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>K</b> Last <b>JACKSON</b>   |   |   |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>17</b> Year <b>19 59</b>  |   |   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>MARCH 11, 1924</b> |  | 9. AGE (In years lost birthday)<br><b>35</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MECHANIC</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>USAF</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>LYNNVILLE, TENNESSEE</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>MITCHELL JACKSON</b>   |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |   | 16. SOCIAL SECURITY NO.<br><b>NOV 43-JUN 59 411-36-4193</b>   |   | INFORMANT<br><b>OFFICIAL AF RECORDS</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA ILEUM</b><br><b>152.7</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)   |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 MONTHS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |   |  |
| 21. I certify that I attended the deceased from <b>6:30 JUN 17, 1959</b> to <b>7:15 JUNE 17 1959</b> that I last saw the deceased alive on <b>7:15 JUNE 17, 1959</b> , and that death occurred at <b>7:15AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED |   |   |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Thomas DB Fennell</b>  |   | M.D. <b>USAF HOSPITAL ANDREWS</b>   |   |  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>THOMAS DB FENNELL CAPT USAF MC USAF HOSPITAL ANDREWS AFB WASHINGTON 25 DC</b>   |   |   |   |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><b>6/19/59</b>   | 22c. NAME OF CEMETERY OR CREMATORY  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Pulaski, Tenn.</b>   |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Jenkins</b>   |   | ADDRESS<br><b>4808 Oak Ave NW</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 27 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>   |  |

MEDICAL CERTIFICATION

2

1

050

STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_

known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of California

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07091

7088

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>STATE Maryland b. COUNTY Prince George |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cheverly  |  | c. LENGTH OF STAY IN 1b<br>4 Days   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Prince George General Hospital  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>15 Hyattsville                              |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Prince George General Hospital  |  | d. STREET ADDRESS<br>4919 49th Ave.   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Dora Middle Lillian Last Joholske  |  | 4. DATE OF DEATH<br>June 29 Day 19 59   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br>Aug. 27, 1891   |  |
| 9. AGE (In years and days)<br>56 67 yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>At home  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Chestertown, Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Charles Hodgkins   |  | 14. MOTHER'S MAIDEN NAME<br>Emma Usilton  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>None  |  | 16. SOCIAL SECURITY NO.<br>None   |  |
| 17. INFORMANT<br>Charles J. Joholske, 4919--49th Ave. Edmonston, Md.  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary emboli, multiple<br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular fibrillation<br>DUE TO (c) Arteriosclerotic heart disease<br>INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>unknown<br>" |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day, Year<br>19  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                       |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from June 25, 19 59, to June 29, 19 59, that I last saw the deceased alive on JUNE 29, 19 59, and that death occurred at 3:20 P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>30-C Bridge Rd, Greenbelt, Md 6-30-59<br>ACTUAL SIGNATURE Dr. Hans Wodak, M.D.<br>PHYSICIAN'S NAME (Type)                      |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 22b. DATE THEREOF<br>July 3, 1959   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Chester Cemetery  |  | 22d. LOCATION (City, town, or county) (State)<br>Chestertown, Maryland  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>W.W. Chambers Company, Riverdale, Md.   |  | 24a. REC'D BY REGISTRAR<br>DATE JUL 6 '59   |  |
| 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Hume  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7055

CERTIFICATE OF DEATH

07092

Reg. Dist. No.

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEO. CO MARYLAND</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEO. CO.</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HYATTSVILLE</b>   |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>15 HYATTSVILLE, MD.</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>HYATTSVILLE NURSING HOME</b>  |                                  |   | d. STREET ADDRESS<br><b>812-THURMAN AVE</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>JOSEPH</b> Last <b>KERBER</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>27</b> Year <b>1959</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 1st, 1886</b>   |  | 9. AGE (In years last birthday) <b>73</b> yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>ILLINOIS</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |   | 13. FATHER'S NAME<br><b>JOHN KERBER</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>ANNA SUTTER</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  |   |
| 16. SOCIAL SECURITY NO.<br><b>—</b>  |                                  | 17. INFORMANT<br><b>William D. Kerber (son)</b> Address <b>812-Thurman Av. Hyattsville, MD.</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a); (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Acute myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Senility</b>              |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 min.</b><br><b>10 yr.</b><br><b>15 yr.</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town)  |                                  | (County)  |  | (State)  |   |
| 21. I certify that I attended the deceased from <b>Sept 1956</b> , to <b>June 27 1959</b> , that I last saw the deceased alive on <b>June 27, 1959</b> , and that death occurred at <b>3:41 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>3141-34th St. N.W., WASH. D.C.</b> DATE SIGNED <b>6-27-59</b> |                                  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>JAMES A. SANDERSON</b>  |                                  | PHYSICIAN'S NAME (Type)<br><b>JAMES A. SANDERSON (M.D.) - 3141-34th ST. N.W., WASH. D.C.</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>6/30/1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT OLIVET CEMETERY</b>   |   |
| 22d. LOCATION (City, town, or county)<br><b>WASHINGTON, D.C.</b>   |                                  | (State)   |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Martin W. Hyson Co.</b>   |                                  | ADDRESS<br><b>1300-N ST. NW WASHINGTON, D.C.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 29 '59</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hana</b>  |                                  |   |  |  |   |



FOR STATE  
HEALTH DEPT.

7089

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07093

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>7 years</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ieland Memorial Hospital</b>   |  |   |  | e. STREET ADDRESS <b>6119 43rd Street</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rose</b> Middle <b>King</b> Last   |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>5</b> Year <b>19 59</b>  |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3-24-07</b>                                      |  |
| 9. AGE (In years last birthday) <b>52</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <b>New York</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME <b>David Weintraub</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>KATE CHERNOVSKY</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |  | 17. INFORMANT Address <b>William King; same address as # 2.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO <b>Cardiovascular renal disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>442X</b><br>DUE TO (c)   |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED <b>June 5, 1959</b>                                      |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>          |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 22b. DATE THEREOF <b>JUNE 7, 1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Dugan</b>   |  |   |  | ADDRESS <b>3501-14th NW</b>   |  | 24a. REC'D BY REGISTRAR <b>DATE JUN 9 '59</b>                        |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>   |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1003

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903

11. 1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7141

## CERTIFICATE OF DEATH

07094

Reg. Dist. No.

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>           |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington 22 DC</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>1 yr</u>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>8170 Allen Town Rd SE, DC 22</u>  |                                  | e. STREET ADDRESS<br><u>8170 Allen Town Rd SE</u>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>Lloyd</u> Last <u>Koenig</u>  |                                  | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>11</u> Year <u>1959</u>  |                                       |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb 3 1888</u> |
| 9. AGE (In years lost birthday)<br><u>71</u> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Store Keeper</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>General</u>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><u>Anacostia DC</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>   |                                       |
| 13. FATHER'S NAME<br><u>Peter Koenig</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Virginia Kidwell</u>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |                                       |
| 17. INFORMANT<br><u>Hilda Virginia CARRICK</u>   |                                  | Address <u>22 DC</u>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute Colitis nonspecific</u><br><u>581.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cirrhosis of liver Hypertrophic</u><br>DUE TO<br>(c) <u>unknown</u>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>natural Causes</u>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>58</u> , to <u>June 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>59</u> , and that death occurred at <u>5:40</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>Paul C Van Vatta</u> M.D. <u>Washington 28 DC</u><br>PHYSICIAN'S NAME (Type) <u>PAUL C VAN VATTA</u> <u>5440 Silver Hill Rd SE</u> |                                  |   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>June 13 - 59</u>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Suitland, Md.</u>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Simmons Bros</u>  |                                  | ADDRESS<br><u>1661-9d Hope St</u>   |                                       |
| 24a. REC'D BY REGISTRAR<br>DATE <u>JUN 15 '59</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Kraus</u>  |                                       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7090

07095

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Colmar Manor</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>3612 40 Place</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLA</b> Middle <b>M.</b> Last <b>hatchford</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>13</b> Year <b>19 59</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/6, 1882</b>  |  |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia Maryland</b>                                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>James Joseph Griffin</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Murphy</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>none</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Mary Barker</b><br><b>606 Kariss Ave. Pa.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>332X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Cerebral Arteriosclerosis 6 wks.</b><br>DUE TO<br>(c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk.</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m.<br>19  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                    |  |
| 20f. (City or town)<br>(County)<br>(State)   |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>May 22, 1959</b> , to <b>June 12, 1959</b> , that I last saw the deceased alive on <b>June 12, 1959</b> , and that death occurred at <b>230 A</b> , from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>L. Levitsky</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>6/13/59</b>   |  |   |  |
| DATE SIGNED  |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>L. Levitsky M.D.</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>6/17/59</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor, Md.</b>                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Valley's Funeral Home</b>   |  |   |  | ADDRESS<br><b>Mt. Rainier Md</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 18 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |   |  |   |  |   |  |

CERTIFICATE OF DEATH

703

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

Vertical text on the right margin, likely a filing or processing stamp, mostly illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7091

07096

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>12 days</b>   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ella</b> Middle <b>Lockard</b> Last   |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>29</b> Year <b>59</b>  |                                     |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/17/75</b> |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Kentucky</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>United States</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |                                     |
| 13. FATHER'S NAME<br><b>Thomas J. Triplett</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy E. Bandy</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |                                     |
| 17. INFORMANT<br><b>Betty Kintner Daughter</b>  |                                  | Address<br><b>Address same</b>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs</b><br><b>15 yrs</b>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day, Year<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from <b>6-17</b> , 19 <b>59</b> , to <b>6-29</b> , 19 <b>59</b> , that I lost saw the deceased alive on <b>June 29</b> , 19 <b>59</b> , and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above.  |                                  |   |                                     |
| ACTUAL SIGNATURE<br><b>John P. Clum</b>   |                                  | ADDRESS (Street, City or town, State)<br><b>Hyattsville Md</b>  |                                     |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Clum</b>  |                                  | DATE SIGNED<br><b>6-30-59</b>   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>7/2/59</b>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor Pr Geo. Md.</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis Gasch's Sons</b>   |                                  | ADDRESS<br><b>Hyattsville, Md.</b>  |                                     |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 6 59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hunt</b>   |                                     |

1582



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07097

7092

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>?</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly 38</b> |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>5805 Landover Road</b>   |                                    | d. STREET ADDRESS<br><b>5805 Landover Road</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>BERTHA JOSEPHINE LUCAS</b>   |                                    | 4. DATE OF DEATH Month Day Year<br><b>June 29 19 59</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>29 Jan. 1888</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>71</b>  |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Wisc.</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                    |   |  |
| 13. FATHER'S NAME<br><b>Erick Anderson</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Hanson</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Harry Lucas</b>  |                                    | Address<br><b>Same as # 2</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Bronchial pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>June 26, 19 59</b> , to <b>June 29, 19 59</b> , that I last saw the deceased alive on <b>June 28, 19 59</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>5304 Annapolis Road</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>William D. Rosson M.D.</b><br>PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, MD.</b> <b>Bladensburg, Maryland</b>    |                                    |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>7/2/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor Pr. Geo. Md.</b>                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis Gasch's Sons</b>  |                                    | ADDRESS<br><b>Hyattsville, Maryland</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>JUL 6 '59</b>  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

# CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| Name of Deceased<br>[Illegible]           |  | Date of Death<br>[Illegible]                |  |
| Age of Deceased<br>[Illegible]            |  | Sex<br>[Illegible]                          |  |
| Race<br>[Illegible]                       |  | Marital Status<br>[Illegible]               |  |
| Usual Residence<br>[Illegible]            |  | Place of Death<br>[Illegible]               |  |
| Cause of Death (Immediate)<br>[Illegible] |  | Cause of Death (Underlying)<br>[Illegible]  |  |
| Physician's Signature<br>[Illegible]      |  | Medical Examiner's Signature<br>[Illegible] |  |
| Date of Signature<br>[Illegible]          |  | Date of Signature<br>[Illegible]            |  |



This certificate is to be filed in the office of the Registrar of the State Department of Health, and a copy thereof to be sent to the local health officer.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film G244 7/9/59 cap

# CERTIFICATE OF DEATH

07098

Reg. Dist. No.

7056

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Washington, D.C.</b> b. COUNTY                         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville, Md.</b>   |  |   |  | c. LENGTH OF STAY IN 1b   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Manor, 4922 La Salle Rd.</b>   |  |   |  | d. STREET ADDRESS<br><b>1610 Riggs Pl. N.W.</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>James</b> Last <b>Mahoney</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>29</b> Year <b>19 59</b>   |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 10, 1887</b>                                     |  |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>80</b> Days <b>81</b> Hours <b>18</b> Min. |  | IF UNDER 24 HRS<br>Months <b>80</b> Days <b>81</b> Hours <b>18</b> Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Passenger Conductor, S.R. Railroad</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mitchells, Virginia.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Simon Mahoney</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Jane O'Day</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>705-01-0129</b>   |  | 17. INFORMANT<br><b>Sr. M. Bernadette Joseph.</b>                            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia - Bilateral lobar</b><br>DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 years-</b><br>DUE TO (c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>6/26/59</b> , 19____, to <b>6/29/1959</b> , 19____, that I last saw the deceased alive on <b>6/29/1959</b> , 19____, and that death occurred at <b>12 noon</b> , from the causes and on the date stated above.   |  |   |  | ADDRESS (Street, city or town, state) <b>322- H. St. N.E.</b> DATE SIGNED <b>6/29/1959</b>  |  |  |  |
| ACTUAL SIGNATURE <b>Thomas F. Collins</b> M.D.  |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. Thomas F. Collins-</b>   |  |   |  | <b>Washington 2, D.C.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>July 1, 1959</b>                                |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Lynchburg, Virginia.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. H. Serrano Jr.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JUL 6 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Smith</b>                         |  |

# CERTIFICATE OF DEATH

1951

|   |  |
|---|--|
| <p>1. Name of Deceased: <b>W. Thomas P. Collins</b></p>         |  |
| <p>2. Date of Death: <b>6/29/1951</b></p>                       |  |
| <p>3. Place of Death: <b>Washington, D.C.</b></p>               |  |
| <p>4. Age: <b>32- H. B. N.E.</b></p>                            |  |
| <p>5. Sex: <b>Male</b></p>                                      |  |
| <p>6. Race: <b>White</b></p>                                    |  |
| <p>7. Cause of Death: <b>Arteriosclerotic Heart Disease</b></p> |  |
| <p>8. Contributing Cause: <b>Pneumonia - Bifurcal Inlet</b></p> |  |
| <p>9. Duration of Illness: <b>2 years</b></p>                   |  |
| <p>10. Date of Birth: <b>6/29/1919</b></p>                      |  |
| <p>11. Date of Death: <b>6/29/1951</b></p>                      |  |
| <p>12. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>13. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>14. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>15. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>16. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>17. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>18. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>19. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>20. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>21. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>22. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>23. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>24. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>25. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>26. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>27. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>28. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>29. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>30. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>31. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>32. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>33. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>34. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>35. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>36. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>37. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>38. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>39. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>40. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>41. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>42. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>43. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>44. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>45. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>46. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>47. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>48. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>49. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>50. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>51. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>52. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>53. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>54. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>55. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>56. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>57. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>58. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>59. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>60. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>61. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>62. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>63. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>64. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>65. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>66. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>67. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>68. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>69. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>70. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>71. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>72. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>73. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>74. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>75. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>76. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>77. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>78. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>79. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>80. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>81. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>82. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>83. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>84. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>85. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>86. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>87. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>88. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>89. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>90. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>91. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>92. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>93. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>94. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>95. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>96. Date of Burial: <b>6/29/1951</b></p>                     |  |
| <p>97. Date of Interment: <b>6/29/1951</b></p>                  |  |
| <p>98. Date of Cremation: <b>6/29/1951</b></p>                  |  |
| <p>99. Date of Disposition: <b>6/29/1951</b></p>                |  |
| <p>100. Date of Burial: <b>6/29/1951</b></p>                    |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7142

## CERTIFICATE OF DEATH

07099

Reg. Dist. No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>PRINCE GEORGE</u> b. COUNTY <u>CLINTON</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CLINTON</u>   | c. LENGTH OF STAY IN 1b          | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CLINTON</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>RFD-1-BOX 460</u>   |                                  | d. STREET ADDRESS<br><u>RFD-1-BOX 460</u>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>MARTTALA</u> Last <u>MARTTALA</u>   |                                  | 4. DATE OF DEATH<br>Month <u>JUNE</u> Day <u>30</u> Year <u>19 59</u>   |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JAN 7-1888</u>   |
| 9. AGE (In years last birthday)<br><u>71</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.  | IF UNDER 24 HRS.<br>Hours <u>1</u> Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CRANE OPERATOR</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STEEL</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>FINLAND</u>                                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                  | 13. FATHER'S NAME<br><u>HENRY MARTTALA</u>  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>MARIA LUOMA</u>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><u>NO</u>  |   |
| 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)  |                                  | 17. INFORMANT<br><u>MARIA MARTTALA-CLINTON MD</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u><br>260X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO (c) <u>DIABETES MELLITUS</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 HOUR</u><br><u>9 MONTHS</u><br><u>1 YEAR</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m.<br>19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>OCT. 13, 1958</u> , to <u>JUN 30, 1959</u> , that I last saw the deceased alive on <u>JUN 30, 1959</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE<br><u>Paul Chen</u>   |                                  | ADDRESS (Street, city or town, state)<br><u>6-30-59</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>PAUL CHEN</u>  |                                  | DATE SIGNED<br><u>ACCOKEEK, MD.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 22b. DATE THEREOF<br><u>7/3/59</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>CAR LAWN</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>COLGATE MD</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>WILFRICH FUNERAL HOME - DUNDALK, MD</u>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 6 '59</u>  |   |
| ADDRESS<br><u>WILFRICH FUNERAL HOME - DUNDALK, MD</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>William S. Knead</u>   |   |





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7143

CERTIFICATE OF DEATH

07160

Reg. Dist. No.

|   |                                 |   |  |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>USAF HOSPITAL ANDREWS</u>  |                                 | d. STREET ADDRESS<br><u>4512 NICHOLS AVE. S.W.</u>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ESTHER BELLE MASHBURN</u>   |                                 | 4. DATE OF DEATH Month Day Year<br><u>JUNE 30 1959</u>  |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>CAUC</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>6 JUNE 1898</u> |
| 9. AGE (In years lost birthday) yrs.<br><u>61</u>   |                                 | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                 | 12. KIND OF BUSINESS OR INDUSTRY<br><u>N/A</u>  |  |
| 13. BIRTHPLACE (State or foreign country)<br><u>DETROIT, MICHIGAN</u>   |                                 | 14. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 15. FATHER'S NAME<br><u>LESLIE BELL</u>   |                                 | 16. MOTHER'S MAIDEN NAME<br><u>MARION UNKNOWN</u>   |  |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |                                 | 18. SOCIAL SECURITY NO.<br><u>NO</u>  |  |
| 19. INFORMANT<br><u>KENNETH KYNETT</u>  |                                 | Address<br><u>4512 NICHOLS AVE. S.W. WASH DC.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident.</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension.</u><br>DUE TO (c)  |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 HRS</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                 | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>30 June</u> , 19 <u>59</u> , to <u>30 June</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>30 June</u> , 19 <u>59</u> , and that death occurred at <u>11:35 P.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>Thomas G Briggs</u> M.D. <u>30 June 59</u> |                                 |   |  |
| ACTUAL SIGNATURE  |                                 | PHYSICIAN'S NAME (Type) <u>THOMAS G BRIGGS, CAPT, USAF (MC)</u> <u>USAF Hosp Andrews, Andrews AFB, Wash 25, D.C.</u>                                      |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                 | 22b. DATE THEREOF<br><u>7-3-59</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>   |                                 | 22d. LOCATION (City, town, or county) (State)<br><u>Arlington, Virginia</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers Co. Inc. Washington, D.C.</u>  |                                 | 24. REC'D BY REGISTRAR<br>DATE <u>JUL 6 '59</u>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. King</u>   |                                 |   |  |



TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 14, 21 Film G244 6-23-59 et

7093

## CERTIFICATE OF DEATH

07101

Reg. Dist. No.

|  |                                  |  |  |  |   |   |                  |
|--|----------------------------------|--|--|--|---|---|------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince Georges'</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>5 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>14 College Park, Maryland</b>                               |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Prince Georges General</b>   |                                  |  |  | d. STREET ADDRESS<br><b>7304 Rhode Island Avenue</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 3. NAME OF DECEASED <b>Lucy Agnes</b> First <b>Gertrude</b> Middle <b>McCarthy</b> Last  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>14</b> Year <b>19 59</b>  |   |   |                  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 11th, 1879</b>  |  | 9. AGE (In years lost birthday) yrs.<br><b>80</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk, Mutilation Sect.</b>  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Bureau of Engrav. Philadelphia, Penn.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |   |                  |
| 13. FATHER'S NAME<br><b>Patrick Joseph McCarthy (Ret.)</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Buoy Buoy</b>   |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>None</b>   |  | 17. INFORMANT<br><b>Miss Katherine E. Crilly, 7304 Rhode Island Ave.,</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>158.1</b> DUE TO <b>Intestinal Botulism</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) <b>Adeno carcinoma of the Transverse Colon.</b><br>DUE TO (c) <b>Intestinal Botulism</b>                   |                                  |  |  |  |   |   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |  |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |                  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <b>6/10/59</b> , 19 <b>59</b> , to <b>6/14/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/14/59</b> , 19 <b>59</b> , and that death occurred at <b>7:30 p.m.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4500 College Avenue, College Park, Md.</b><br>DATE SIGNED <b>6/14/59.</b> |                                  |  |  |  |   |   |                  |
| ACTUAL SIGNATURE <b>Wm. A. Holbrook</b> M.D.   |                                  |  |  | DATE SIGNED <b>6/14/59.</b>  |   |   |                  |
| PHYSICIAN'S NAME (Type) <b>Dr. Wm. A. Holbrook</b>   |                                  |  |  | <b>4500 College Avenue, College Park, Md.</b>  |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>June 17, 1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>                         |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. W. CHAMBERS CO.,</b>   |                                  |  |  | ADDRESS<br><b>Riverdale, Maryland,</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 18 '59</b>   |                  |
|  |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>   |   |   |                  |

CERTIFICATE OF DEATH

|                      |  |                         |  |                       |  |                            |  |                              |  |                           |  |                      |  |                           |  |                           |  |
|----------------------|--|-------------------------|--|-----------------------|--|----------------------------|--|------------------------------|--|---------------------------|--|----------------------|--|---------------------------|--|---------------------------|--|
| 1. Name of deceased  |  | 2. Sex                  |  | 3. Age                |  | 4. Date of birth           |  | 5. Date of death             |  | 6. Place of death         |  | 7. Cause of death    |  | 8. Signature of physician |  | 9. Signature of registrar |  |
| John Doe             |  | Male                    |  | 45                    |  | Jan 1, 1920                |  | Jan 15, 1965                 |  | Birmingham, Ala.          |  | Heart disease        |  | [Signature]               |  | [Signature]               |  |
| 10. Occupation       |  | 11. Marital status      |  | 12. Education         |  | 13. Religion               |  | 14. Race                     |  | 15. Birthplace            |  | 16. Usual residence  |  | 17. Informant             |  | 18. Informant's address   |  |
| Teacher              |  | Married                 |  | High School           |  | Methodist                  |  | White                        |  | Alabama                   |  | Birmingham           |  | John Doe                  |  | 123 Main St.              |  |
| 19. Informant's name |  | 20. Informant's address |  | 21. Informant's phone |  | 22. Informant's occupation |  | 23. Informant's relationship |  | 24. Informant's signature |  | 25. Informant's date |  | 26. Informant's address   |  | 27. Informant's phone     |  |
| John Doe             |  | 123 Main St.            |  | 123-4567              |  | Teacher                    |  | Son                          |  | [Signature]               |  | Jan 15, 1965         |  | 123 Main St.              |  | 123-4567                  |  |

1

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

| 7094 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |  |   |   |   |  |   |  |  | 07102  |  |
|--|--|--|---|---|---|--|---|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |   |   |   |  |   |  |  | Reg. Dist. No.   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>   |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> |  |   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>2 hrs</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>15 Hyattsville</b>   |  |   |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |  |  |   |   | d. STREET ADDRESS<br><b>1 7904 -15th Ave.</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby</b> Middle <b>Boy</b> Last <b>McPhee</b>  |  |  |   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>4</b> Year <b>19 59</b>  |  |   |  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>         |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>4 June 1959</b>                       |   | 9. AGE (In years lost birthday) yrs.<br><b>2</b>                                       |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>        |  |  |
| 13. FATHER'S NAME<br><b>Gordon McPhee</b>  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Delores Samuels</b>  |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |   | 17. INFORMANT   |  |   | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity 2 lbs 15 oz</b><br><b>762.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic pulmonary ventilation &amp; respiratory collapse</b><br>DUE TO (c) |  |  |   |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |   |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>6/4</b> , 19 <b>59</b> , to <b>6/4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/4</b> , 19 <b>59</b> , and that death occurred at <b>7.00A</b> M, from the causes and on the date stated above.  |  |  |   |   |   |  |   |  |  |  |  |
| ACTUAL SIGNATURE <b>Thomas A. Christensen</b>  |  |  | M.D. <b>Colgate Park</b>  |   |   | ADDRESS (Street, city or town, state)                        |   |  | DATE SIGNED <b>6/5/59</b>                            |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. F. Warren, M.D.</b>  |  |  |   |   |   |  |   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>JUNE 9, 1959</b> |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATL</b>   |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>ARLINGTON VA.</b> |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Talbot</b>   |  |  |   |   | ADDRESS<br><b>3603 14th St NW</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 8 '59</b>                      |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |  |  |

2077242XVI





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07103

7095

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince Georges</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>24 hours</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>4012 Kennedy St.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Dora</b> Middle <b>Codelia</b> Last <b>Moffett</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>5</b> Year <b>1959</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>                                     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/21/94</b>   |  |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min. |  | IF UNDER 24 HRS.<br>Hours <b>5</b> Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>David Ball</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Fannie Holmes</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                               |  | 17. INFORMANT<br><b>Clarence Husband</b> Address <b>same</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, left</b><br><b>332x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Arteriosclerotic heart disease</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs</b><br><b>YEARS.</b> |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b> 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                 |  |
| 20f. (City or town) (County) (State)   |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>June 5</b> , 19 <b>59</b> , to <b>June 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 5</b> , 19 <b>59</b> , and that death occurred at <b>10:45P</b> M, from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John H. Bayly</b> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <b>1835 Eye St N.W.</b> DATE SIGNED <b>6 June 59</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>John H. Bayly</b>   |  |  |  | <b>WASH. D.C.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>6/8/59</b>                                   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Colmar Manor Md.</b>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>   |  |  |  | ADDRESS<br><b>Hyattsville, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 9 '59</b>   |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kenna</b>  |  |  |  |

# CERTIFICATE OF DEATH

7095

|                  |  |                     |  |                       |  |                      |  |
|------------------|--|---------------------|--|-----------------------|--|----------------------|--|
| Name of Deceased |  | Sex                 |  | Age                   |  | Date of Birth        |  |
| John Doe         |  | Male                |  | 45                    |  | 1930-01-15           |  |
| Place of Birth   |  | Cause of Death      |  | Date of Death         |  | Time of Death        |  |
| New York City    |  | Heart Disease       |  | 1975-03-10            |  | 10:30 AM             |  |
| Occupation       |  | Manner of Death     |  | Physician's Signature |  | Hospital/Institution |  |
| Teacher          |  | Natural             |  | [Signature]           |  | St. Mary's Hospital  |  |
| Usual Residence  |  | Place of Death      |  | Burial Place          |  | Burial Date          |  |
| 123 Main St, NYC |  | St. Mary's Hospital |  | St. Mary's Cemetery   |  | 1975-03-12           |  |

|                      |  |                          |  |                        |  |
|----------------------|--|--------------------------|--|------------------------|--|
| Name of Informant    |  | Relationship to Deceased |  | Signature of Informant |  |
| Jane Doe             |  | Wife                     |  | [Signature]            |  |
| Address of Informant |  | Date of Statement        |  | Signature of Registrar |  |
| 456 Elm St, NYC      |  | 1975-03-11               |  | [Signature]            |  |
| County of Death      |  | City of Death            |  | State of Death         |  |
| New York             |  | New York                 |  | New York               |  |
| Date of Statement    |  | Signature of Registrar   |  | Official Seal          |  |
| 1975-03-11           |  | [Signature]              |  | [Seal]                 |  |

7144

CERTIFICATE OF DEATH

07104

Reg. Dist. No.

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGE</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>         |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CORAL HILLS</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>18 YEARS X</b>  |  |  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CORAL HILLS</b>  |  |   |  | d. STREET ADDRESS <b>15205 P ST. S.E.</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLA</b> Middle <b>MAE</b> Last <b>MORELAND</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>30</b> Year <b>1959</b>   |  |  |   |
| 5. SEX <b>FEMALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>OCT 14, 1878? 81?</b>                              |   |
| 9. AGE (In years lost birthday) <b>81?</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>AWNING</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>            |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  |  |  |  |   |
| 13. FATHER'S NAME <b>NIEMYER N. MORELAND</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH MOORE</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <b>579-484630</b>  |  |  |   |
| INFORMANT <b>(SISTER) ANNIE FOWLER</b>   |  |   |  | Address <b>5205 P ST S.E.</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC DECOMPENSATION</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY ARTERIOSCLEROSIS</b><br>DUE TO (c)                       |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 MOS.</b><br><b>18 MOS.</b>                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |  |   |
| 21. I certify that I attended the deceased from <b>OCT 15, 1957</b> to <b>JUNE 30, 1959</b> , that I last saw the deceased alive on <b>JUNE 30, 1959</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>2436 L'ENFANT SQUARE, S.E.</b> DATE SIGNED <b>JUNE 30, 1959</b> |  |   |  |  |  |  |   |
| ACTUAL SIGNATURE <b>Vincent J. Di Francesco M.D.</b>   |  |   |  |  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>(VINCENT J. DI FRANCESCO)</b>   |  |   |  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF                         |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |   |
| <b>Burial</b>  |  | <b>7-3-59</b>                             |  | <b>Bedar Hill</b>  |  | <b>Smithland, Md</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>  |  |   |  | ADDRESS <b>131-11 SE</b>   |  | 24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>                               |   |
|  |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE <b>William S. Krueger</b>                   |   |

1

1

1

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7096

## CERTIFICATE OF DEATH

07105

Reg. Dist. No.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riverdale</u>   |   | c. LENGTH OF STAY IN 1b<br><u>8 1/2 hrs.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington Eastern Ave.</u> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Eugene Deland Mem. Hosp.</u>  |   |   | d. STREET ADDRESS<br><u>14633 Eastern</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Joseph</u> Middle <u>Notes</u> Last <u>Notes</u>   |   |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>24</u> Year <u>1959</u>  |  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-7-1913</u>   | 9. AGE <u>45</u> years last birthday<br><u>55</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Lawyer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dist. Govt.</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Wash. D. C.</u>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |   | 13. FATHER'S NAME<br><u>David Notes</u>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Rosie Bollitt</u> GENSBERG  |   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  |   |
| 16. SOCIAL SECURITY NO.<br><u>  </u>   |   |   | 17. INFORMANT<br><u>Hosp. Records</u> Address <u>  </u>   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br><u>331x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 hours</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that I attended the deceased from <u>June 24</u> , 19 <u>59</u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.   |   |   |   |  |   |
| ACTUAL SIGNATURE<br><u>L W Malin</u>   |   | ADDRESS (Street, city or town, state)<br><u>Riverdale, Md</u> DATE SIGNED <u>6-24-59</u>  |   |  |   |
| PHYSICIAN'S NAME (Type)<br><u>L W Malin M.D.</u>   |   |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>6/26/59</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Prince George's Maryland</u>                                   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph &amp; Sons Inc.</u>  |   | ADDRESS<br><u>7756 Pa Ave</u><br><u>W. D. C.</u>  |   | 24a. REC'D BY REGISTRAR<br><u>  </u> DATE <u>  </u>  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur E. Thomas</u>   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7057

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07106

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                        |  |                                |
|---|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH Sacred Heart Home<br>a. COUNTY Prince George, Hyattsville, MARYLAND   |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Prince George                       |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                        | c. LENGTH OF STAY IN 1b  |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home  |                        | d. STREET ADDRESS 5805 Queens Chapel Road  |                                |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                        |  |                                |
| 3. NAME OF DECEASED (Type or print) Catherine Mary O'Connor   |                        | 4. DATE OF DEATH June 30 1959  |                                |
| 5. SEX Female   | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 5, 1866 |
| 9. AGE (In years last birthday) 92 yrs.   |                        | IF UNDER 1 YEAR Months 9 Days 4 Hours Min.   |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                        | 10b. KIND OF BUSINESS OR INDUSTRY  |                                |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C.  |                        | 12. CITIZEN OF WHAT COUNTRY? United States   |                                |
| 13. FATHER'S NAME Edward O'Connor   |                        | 14. MOTHER'S MAIDEN NAME Mary A. Herbert   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown  |                        | 16. SOCIAL SECURITY NO.  |                                |
| 17. INFORMANT Sacred Heart Home   |                        | Address Hyattsville, MD.   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS<br>DUE TO C MYOCARDIAL INFARCTION<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE<br>DUE TO (c) |                        | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 5 YEARS  |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that I attended the deceased from JAN 1, 1958, to JUNE 30, 1959, that I lost s/he the deceased alive on JUNE 29, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above.   |                        |  |                                |
| ACTUAL SIGNATURE Thomas F. Collins M.D.   |                        | ADDRESS (Street, city or town, state) 322-H 01 NE  |                                |
| DATE SIGNED   |                        |  |                                |
| PHYSICIAN'S NAME (Type) THOMAS F. COLLINS M.D.  |                        |  |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                        | 22b. DATE THEREOF 7-3-1959   |                                |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet   |                        | 22d. LOCATION (City, town, or county) State  |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. Saffell   |                        | ADDRESS 475-H-71   |                                |
| 24a. REC'D BY REGISTRAR DATE JUL 6 '59  |                        | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas  |                                |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7145

CERTIFICATE OF DEATH

07107

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Pr. Georges</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL</u>  |                                  | c. LENGTH OF STAY IN 1b <u>15 YRS</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2700 LIVINGSTON RD. S.E.</u>   |                                  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LANCASTER JOSEPH OWENS</u>  |                                  | 4. DATE OF DEATH Month Day Year <u>JUNE 26<sup>TH</sup> 1959</u>   |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB. 26<sup>TH</sup> 1890</u>                  |
| 9. AGE (In years last birthday) <u>69</u> yrs.   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 11a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>RETIRED</u>   |                                  | 11b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>   |  |
| 12. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |                                  | 13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 14. FATHER'S NAME <u>JOHN D. OWENS</u>   |                                  | 15. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH QUADE</u>   |  |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                                  | 17. SOCIAL SECURITY NO. <u>NONE</u>  |  |
| 18. INFORMANT <u>MARY OWENS (WIFE)</u>   |                                  | Address <u>5100 LIVINGSTON RD SE</u>   |  |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u><br>420.1 DUE TO <u>Coronary Heart Sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 years</u><br>(c) <u>1 day</u> |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>JUNE 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>59</u> , and that death occurred at <u>11:55</u> A.M., from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <u>Max E. Feldman</u>   |                                  | DATE SIGNED <u>June 26, 1959</u>   |  |
| PHYSICIAN'S NAME (Type) <u>MAX E. FELDMAN M.D.</u>   |                                  | ADDRESS (Street, city or town, state) <u>3800 S. Capitol St. Wash. 20 D.C.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>6-29-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wash Natl Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Smithland Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr.</u>   |                                  | ADDRESS <u>517 11th St SE</u>  |  |
| 24a. RECEIVED BY REGISTRAR <u>JUN 30 '59</u>   |                                  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>   |  |

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07108

7097

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATED <b>D.C.</b> b. COUNTY                                     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> <b>47X-3</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>George Dewey Parran, Jr.</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>6 27 1959</b>   |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>colored</b>            |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>3-9-36</b>  |  |
| 9. AGE (In years last birthday)<br><b>23</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Sanatorium</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>George Dewey Parran</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Harvey</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-32-9816</b>  |  | 17. INFORMANT<br><b>George D. Parran, Sr.</b> Address <b>4708 R.I. Ave., Hattsville, Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Compression of medulla by dislocation of 2nd cervical vertebra.</b><br>(c) <b>2nd cervical vertebra.</b><br>COUSE lost.   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Operator of a motor cycle in collision with a culvert</b> |  |  |  |
| 20c. TIME OF INJURY<br>Hour <b>2:10</b> p.m. Month, Day, Year <b>6-27-59</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>     |  |
| 20f. (City or town)<br><b>Glen Dale</b>   |  |   |  | 20g. (County)<br><b>Pr. Geo.</b>   |  | 20h. (State)<br><b>Md.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John T. Maloney</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type)<br><b>John T. Maloney, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 27, 1959</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>7-1-59 Woodlawn Cem.</b>  |  | 22b. DATE THEREOF                             |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>4611 Benning rd N.E.</b>  |  | 22d. LOCATION (City, town, or county) (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Henry S. Washington</b>  |  |   |  | ADDRESS<br><b>Seas-467-77 S.W.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>JUL 2 '59</b>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanes</b>   |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MISSISSIPPI STATE  
DEPARTMENT OF HEALTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

COLOR

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07109

7098

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |   |   |   |  |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2 hrs</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Seat Pleasant</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>513 Addison Road</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Garlen</b> Middle <b>S</b> Last <b>Paxson</b> Sr   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7</b> Year <b>19 59</b>  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>19 July 1902</b> |   | 9. AGE (In years lost birthday)<br><b>56</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Walter. Paxson</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Etta. Moran</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br><b>213.16.2646</b>   |   | 17. INFORMANT<br><b>Delores. Paxson. 513. Addison. rd. Seat. Pl. Md</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Dysfunction due to</b><br><b>420.1</b> DUE TO <b>Coronary Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V.R. Disease</b><br>DUE TO (c) <b>Diabetes Mellitus</b> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>7 years</b>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>   |                                  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>June 1, 1959</b> to <b>June 2, 1959</b> , that I last saw the deceased alive on <b>June 7, 1959</b> , and that death occurred at <b>2:50 A.M.</b> from the causes and on the date stated above.   |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>William Brainin</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>6124 Central Ave</b>  |   |   |   | DATE SIGNED<br><b>6/2/59</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. William Brainin, M.D.</b>  |                                  | <b>Capital City Md</b>  |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>6.10.1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Washington. D C.</b>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>LEE FUNERAL HOME . 300. 4th St NE</b>   |                                  |   |   | ADDRESS<br><b>DATE JUN 10 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |  |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
CERTIFICATE OF DEATH

1903

ATTEST  
I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State Department of Health.  
J. H. HARRIS, Secretary

|                             |  |                |  |
|-----------------------------|--|----------------|--|
| Name of Deceased            |  | John Doe       |  |
| Age                         |  | 25             |  |
| Sex                         |  | Male           |  |
| Race                        |  | White          |  |
| Marital Status              |  | Single         |  |
| Occupation                  |  | Student        |  |
| Cause of Death              |  | Typhoid Fever  |  |
| Date of Death               |  | April 15, 1903 |  |
| Place of Death              |  | Home           |  |
| Signature of Physician      |  | J. H. Harris   |  |
| Signature of Registrar      |  | J. H. Harris   |  |
| Signature of Coroner        |  | J. H. Harris   |  |
| Signature of Burial Officer |  | J. H. Harris   |  |
| Signature of Minister       |  | J. H. Harris   |  |
| Signature of Undertaker     |  | J. H. Harris   |  |
| Signature of Family         |  | J. H. Harris   |  |
| Signature of Friends        |  | J. H. Harris   |  |
| Signature of Neighbors      |  | J. H. Harris   |  |
| Signature of Community      |  | J. H. Harris   |  |
| Signature of State          |  | J. H. Harris   |  |
| Signature of Nation         |  | J. H. Harris   |  |
| Signature of World          |  | J. H. Harris   |  |

FOR STATE  
HEALTH DEPT.

7099

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07110

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN lb <b>D.O.A.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>   |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>   |  |
| f. STREET ADDRESS <b>7107 Glenridge Drive</b>   |                                  | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>David</b> Middle <b>William</b> Last <b>Perkinson</b>   |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>21</b> Year <b>1959</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>white</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH <b>6-10-59</b>  |
| 9. AGE (in years last birthday) <b>11</b>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Thomas Edward Perkinson</b>  |                                  | 14. MOTHER'S MAIDEN NAME <b>Lillian Jane Strong</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Thomas Perkinson; same address</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Icterus neonatorum</b><br><b>773.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                     |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour <b>19</b> Month, Day, Year  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>   |                                  | DATE SIGNED  |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6-21-59</b> |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>6/22/59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gaschs Sons</b> ADDRESS <b>Hyattsville MD.</b>   |                                  | 24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                      |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7058

## CERTIFICATE OF DEATH

07111

Reg. Dist. No.

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>           |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HYATTSVILLE</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 year</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOME</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>15 HYATTSVILLE</b>   |                                    |
| d. STREET ADDRESS<br><b>5805 Queens Chapel Road</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HENRIETTA</b> Middle <b>E.</b> Last <b>PERRY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>17</b> Year <b>1959</b>   |                                    |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-9-68</b> |
| 9. AGE (In years last birthday)<br><b>90</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>FRANCIS A. WALLIS</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>GEORGIANNA WILLSON</b> <b>N.W.</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.   |                                    |
| 17. INFORMANT<br><b>MRS. CHARLES V. STIEFEL</b>   |                                  | Address <b>#3225 Garfield WASH. D. C.</b>   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis with Myocardial Infarction-</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b><br><b>5 years</b> |                                  |   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>9/2/1955</b> , 19____, to <b>6/17/1959</b> , 19____, that I last saw the deceased alive on <b>6/16/1959</b> , 19____, and that death occurred at <b>4</b> A.M., from the causes and on the date stated above.  |                                  |   |                                    |
| ACTUAL SIGNATURE <b>Thomas F. Collins</b>   |                                  | ADDRESS (Street, city or town, state) <b>322- H. Street, N.E.</b> DATE SIGNED <b>6/17/59</b>  |                                    |
| PHYSICIAN'S NAME (Type) <b>THOMAS F. COLLINS M.D.</b>   |                                  | <b>Washington 2, D.C.</b>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>6-19-59</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>CHESTERFIELD CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>CENTREVILLE, MARYLAND.</b>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>  |                                  | ADDRESS <b>WASH. D. C.</b>  |                                    |
| 24a. REC'D BY REGISTRAR<br><b>Francis J. Collins</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                    |

CERTIFICATE OF DEATH

2057

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>HOME   |  | 2. PLACE OF BIRTH<br>BALTIMORE                    |  |
| 3. SEX<br>MALE  |  | 4. AGE<br>2 years                                 |  |
| 5. RACE<br>WHITE  |  | 6. OCCUPATION<br>INFANT                           |  |
| 7. MARITAL STATUS<br>SINGLE   |  | 8. DATE OF DEATH<br>JAN 11 1929                   |  |
| 9. TIME OF DEATH<br>11:00 AM  |  | 10. CAUSE OF DEATH<br>ARTERIOLECTIC HEART DISEASE |  |
| 11. MEDICAL HISTORY<br>CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION |  | 12. DATE OF ONSET<br>JAN 11 1929                  |  |
| 13. PREVIOUS ILLNESS<br>ARTERIOLECTIC HEART DISEASE                   |  | 14. DATE OF ONSET<br>JAN 11 1929                  |  |
| 15. TREATMENT<br>NONE   |  | 16. DATE OF DEATH<br>JAN 11 1929                  |  |
| 17. SIGNATURE OF PHYSICIAN<br>J. H. STREET, M.D.                      |  | 18. SIGNATURE OF REGISTRAR<br>J. H. STREET, M.D.  |  |
| 19. ADDRESS OF PHYSICIAN<br>322 - H. Street, N.E.                     |  | 20. ADDRESS OF REGISTRAR<br>322 - H. Street, N.E. |  |
| 21. CITY<br>WASHINGTON, D.C.  |  | 22. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 23. STATE<br>D.C.   |  | 24. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 25. CITY<br>WASHINGTON, D.C.  |  | 26. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 27. STATE<br>D.C.   |  | 28. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 29. CITY<br>WASHINGTON, D.C.  |  | 30. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 31. STATE<br>D.C.   |  | 32. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 33. CITY<br>WASHINGTON, D.C.  |  | 34. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 35. STATE<br>D.C.   |  | 36. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 37. CITY<br>WASHINGTON, D.C.  |  | 38. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 39. STATE<br>D.C.   |  | 40. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 41. CITY<br>WASHINGTON, D.C.  |  | 42. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 43. STATE<br>D.C.   |  | 44. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 45. CITY<br>WASHINGTON, D.C.  |  | 46. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 47. STATE<br>D.C.   |  | 48. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 49. CITY<br>WASHINGTON, D.C.  |  | 50. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 51. STATE<br>D.C.   |  | 52. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 53. CITY<br>WASHINGTON, D.C.  |  | 54. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 55. STATE<br>D.C.   |  | 56. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 57. CITY<br>WASHINGTON, D.C.  |  | 58. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 59. STATE<br>D.C.   |  | 60. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 61. CITY<br>WASHINGTON, D.C.  |  | 62. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 63. STATE<br>D.C.   |  | 64. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 65. CITY<br>WASHINGTON, D.C.  |  | 66. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 67. STATE<br>D.C.   |  | 68. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 69. CITY<br>WASHINGTON, D.C.  |  | 70. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 71. STATE<br>D.C.   |  | 72. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 73. CITY<br>WASHINGTON, D.C.  |  | 74. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 75. STATE<br>D.C.   |  | 76. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 77. CITY<br>WASHINGTON, D.C.  |  | 78. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 79. STATE<br>D.C.   |  | 80. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 81. CITY<br>WASHINGTON, D.C.  |  | 82. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 83. STATE<br>D.C.   |  | 84. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 85. CITY<br>WASHINGTON, D.C.  |  | 86. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 87. STATE<br>D.C.   |  | 88. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 89. CITY<br>WASHINGTON, D.C.  |  | 90. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 91. STATE<br>D.C.   |  | 92. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 93. CITY<br>WASHINGTON, D.C.  |  | 94. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 95. STATE<br>D.C.   |  | 96. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 97. CITY<br>WASHINGTON, D.C.  |  | 98. COUNTY<br>DISTRICT OF COLUMBIA                |  |
| 99. STATE<br>D.C.   |  | 100. COUNTY<br>DISTRICT OF COLUMBIA               |  |

1



7146

## CERTIFICATE OF DEATH

07112

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>PRINCE GEORGES</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANDREWS AFB</b>   |   | c. LENGTH OF STAY IN 1b<br><b>15 DAYS</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>USAF HOSPITAL ANDREWS</b>   |   | d. STREET ADDRESS<br><b>5832 RITCHIE ROAD</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>F</b> Last <b>PETTIT</b>  |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>15</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>CAUC</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>24 Jan 1894</b>  |
| 9. AGE (In years lost birthday) yrs.<br><b>65</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PHARMACIST</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>USN</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>ARTHUR J PETTIT</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY CECILIA BEAN</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |   | 16. SOCIAL SECURITY NO.<br><b>1931 RETIRED NA</b>   |   |
| 17. INFORMANT<br><b>KATHERINE M PETTIT</b>   |   | Address <b>5832 RITCHIE ROAD FORESTVILLE, MARYLAND</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b><br><b>260X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO<br>(c) <b>DIABETES MELLITUS - ARTERIOSCLEROSIS</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>26 HOURS</b><br><b>15 YEARS</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>30 MAY</b> , 1959, to <b>15 JUNE</b> , 1959, that I last saw the deceased alive on <b>15 JUNE</b> , 1959, and that death occurred at <b>10:07 A</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>Reginald P McManus</b> M.D. <b>USAF HOSPITAL ANDREWS</b> <b>15 June 59</b><br>PHYSICIAN'S NAME (Type) <b>REGINALD P McMANUS CAPT USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25</b> |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>6-18-59</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia D.C.</b>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James T. Ryan, Inc.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 17 '59</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanks</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7100

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07113

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <b>Maryland</b> c. COUNTY <b>Prince George</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>3 hrs 55 min.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Prince George General</b>  |  |   |  | d. STREET ADDRESS<br><b>3411 Stanford St.,</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Shirley Ann Phoebus</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 24 1959</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 14-9-1934</b>  |  |
| 9. AGE (In years last birthday)<br><b>24 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                         |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Travel Consultant</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>A.A.A.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington D. C.</b>                                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Watler L Phoebus</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie R Regan</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) |  | 17. INFORMANT<br><b>Walter L Phoebus</b> Address <b>Hyattsville, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral accident -</b><br><b>445X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b) <b>malignant Hypertension</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>moments</b><br><b>3 mo.</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                 |  |
| 20f. (City or town)<br>(County)<br>(State)   |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>June 23 1959</b> , to <b>June 24 1959</b> , that I last saw the deceased alive on <b>June 24 1959</b> , and that death occurred at <b>2:25</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>6304 Annapolis Rd</b> DATE SIGNED <b>6-24-59</b>  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Dr. D.O. Watkins</b>   |  |   |  | M.D. <b>Bladensburg Md</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>6/27/59</b>                               |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |  | 22d. LOCATION (City, town, or county)<br><b>Colmar Manor, Md.</b>                                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch*s Sons</b> ADDRESS <b>Hyattsville, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 29 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. House</b>   |  |

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

File No.

Decedent's Name

Date of Death

Place of Death

Age

Sex

Color

Marital Status

Occupation

Education

Usual Residence

Place of Birth

Country of Birth

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Medical History

Present Illness

Examination

Postmortem

Disposition

Remarks

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Examiner

Signature of Toxicologist

Signature of Chemist

Signature of Bacteriologist

Signature of Microscopist

Signature of Radiologist

Signature of Anatomist

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G244 7-2-59 at

7147

CERTIFICATE OF DEATH

07114

Reg. Dist. No.

|   |                               |  |  |  |   |  |  |
|---|-------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxscombville</u>   |                               |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crookers Rest Home</u>  |                               |  |  | d. STREET ADDRESS <u>11914 116th Rd.</u>   |   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Walter D. Pinkney</u>  |                               |  |  | 4. DATE OF DEATH <u>June 28</u> 19 <u>59</u>   |   |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 12, 1907</u> | 9. AGE (In years last birthday) <u>52</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State of foreign country) <u>md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |  |
| 13. FATHER'S NAME <u>John Henry Pinkney</u>   |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>Dusie Briggs</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |                               | 16. SOCIAL SECURITY NO. <u>1</u>   |  | 17. INFORMANT <u>John B. Pinkney - 6350 Brooks Rd SE</u>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Attack</u><br>420.1 DUE TO <u>Hypertensive C.V. H.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage + Hemiplegia</u><br>DUE TO <u>4 yrs.</u><br>(c) <u>Diabetes mellitus - Rt. Leg High Amputation</u> |                               |  |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - Rt. Leg High Amputation</u>  |                               |  |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day, Year 19   |                               |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                      |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|   |                               |  |  | 20f. (City or town) (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>June 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>59</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.  |                               |  |  |  |   |  |  |
| ACTUAL SIGNATURE <u>John W. Robinson</u> M.D.   |                               |  |  | DATE SIGNED <u>1001 Eastern Ave. N.E.</u>  |   |  |  |
| PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>   |                               |  |  | <u>1001 Eastern Ave. N.E.</u>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>7/1/59</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>   |   | 22d. LOCATION (City, town, or county) (State) <u>B.C.</u>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>   |                               |  |  | ADDRESS <u>30-H St. N. 15</u>  |   | 24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>                         |  |
|   |                               |  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>  |   |  |  |

CERTIFICATE OF DEATH

1147

THE DAY OF

|                                 |  |  |  |
|---------------------------------|--|--|--|
| PLACE OF DEATH<br>COUNTY        |  | DECEASED<br>NAME   |  |
| DATE OF DEATH<br>YEAR MONTH DAY |  | SEX<br>MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> |  |
| PLACE OF BIRTH<br>COUNTY        |  | AGE<br>YEARS MONTHS DAYS   |  |
| OCCUPATION<br>TRADE             |  | CAUSE OF DEATH<br>1.   |  |
| CAUSE OF DEATH<br>2.            |  | CAUSE OF DEATH<br>3.   |  |
| CAUSE OF DEATH<br>4.            |  | CAUSE OF DEATH<br>5.   |  |
| CAUSE OF DEATH<br>6.            |  | CAUSE OF DEATH<br>7.   |  |
| CAUSE OF DEATH<br>8.            |  | CAUSE OF DEATH<br>9.   |  |
| CAUSE OF DEATH<br>10.           |  | CAUSE OF DEATH<br>11.  |  |
| CAUSE OF DEATH<br>12.           |  | CAUSE OF DEATH<br>13.  |  |
| CAUSE OF DEATH<br>14.           |  | CAUSE OF DEATH<br>15.  |  |
| CAUSE OF DEATH<br>16.           |  | CAUSE OF DEATH<br>17.  |  |
| CAUSE OF DEATH<br>18.           |  | CAUSE OF DEATH<br>19.  |  |
| CAUSE OF DEATH<br>20.           |  | CAUSE OF DEATH<br>21.  |  |
| CAUSE OF DEATH<br>22.           |  | CAUSE OF DEATH<br>23.  |  |
| CAUSE OF DEATH<br>24.           |  | CAUSE OF DEATH<br>25.  |  |
| CAUSE OF DEATH<br>26.           |  | CAUSE OF DEATH<br>27.  |  |
| CAUSE OF DEATH<br>28.           |  | CAUSE OF DEATH<br>29.  |  |
| CAUSE OF DEATH<br>30.           |  | CAUSE OF DEATH<br>31.  |  |
| CAUSE OF DEATH<br>32.           |  | CAUSE OF DEATH<br>33.  |  |
| CAUSE OF DEATH<br>34.           |  | CAUSE OF DEATH<br>35.  |  |
| CAUSE OF DEATH<br>36.           |  | CAUSE OF DEATH<br>37.  |  |
| CAUSE OF DEATH<br>38.           |  | CAUSE OF DEATH<br>39.  |  |
| CAUSE OF DEATH<br>40.           |  | CAUSE OF DEATH<br>41.  |  |
| CAUSE OF DEATH<br>42.           |  | CAUSE OF DEATH<br>43.  |  |
| CAUSE OF DEATH<br>44.           |  | CAUSE OF DEATH<br>45.  |  |
| CAUSE OF DEATH<br>46.           |  | CAUSE OF DEATH<br>47.  |  |
| CAUSE OF DEATH<br>48.           |  | CAUSE OF DEATH<br>49.  |  |
| CAUSE OF DEATH<br>50.           |  | CAUSE OF DEATH<br>51.  |  |
| CAUSE OF DEATH<br>52.           |  | CAUSE OF DEATH<br>53.  |  |
| CAUSE OF DEATH<br>54.           |  | CAUSE OF DEATH<br>55.  |  |
| CAUSE OF DEATH<br>56.           |  | CAUSE OF DEATH<br>57.  |  |
| CAUSE OF DEATH<br>58.           |  | CAUSE OF DEATH<br>59.  |  |
| CAUSE OF DEATH<br>60.           |  | CAUSE OF DEATH<br>61.  |  |
| CAUSE OF DEATH<br>62.           |  | CAUSE OF DEATH<br>63.  |  |
| CAUSE OF DEATH<br>64.           |  | CAUSE OF DEATH<br>65.  |  |
| CAUSE OF DEATH<br>66.           |  | CAUSE OF DEATH<br>67.  |  |
| CAUSE OF DEATH<br>68.           |  | CAUSE OF DEATH<br>69.  |  |
| CAUSE OF DEATH<br>70.           |  | CAUSE OF DEATH<br>71.  |  |
| CAUSE OF DEATH<br>72.           |  | CAUSE OF DEATH<br>73.  |  |
| CAUSE OF DEATH<br>74.           |  | CAUSE OF DEATH<br>75.  |  |
| CAUSE OF DEATH<br>76.           |  | CAUSE OF DEATH<br>77.  |  |
| CAUSE OF DEATH<br>78.           |  | CAUSE OF DEATH<br>79.  |  |
| CAUSE OF DEATH<br>80.           |  | CAUSE OF DEATH<br>81.  |  |
| CAUSE OF DEATH<br>82.           |  | CAUSE OF DEATH<br>83.  |  |
| CAUSE OF DEATH<br>84.           |  | CAUSE OF DEATH<br>85.  |  |
| CAUSE OF DEATH<br>86.           |  | CAUSE OF DEATH<br>87.  |  |
| CAUSE OF DEATH<br>88.           |  | CAUSE OF DEATH<br>89.  |  |
| CAUSE OF DEATH<br>90.           |  | CAUSE OF DEATH<br>91.  |  |
| CAUSE OF DEATH<br>92.           |  | CAUSE OF DEATH<br>93.  |  |
| CAUSE OF DEATH<br>94.           |  | CAUSE OF DEATH<br>95.  |  |
| CAUSE OF DEATH<br>96.           |  | CAUSE OF DEATH<br>97.  |  |
| CAUSE OF DEATH<br>98.           |  | CAUSE OF DEATH<br>99.  |  |
| CAUSE OF DEATH<br>100.          |  | CAUSE OF DEATH<br>101.   |  |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07115

Item 22 FilmG244 7-6-59 at

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Seat Pleasant</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>Washington</b> <span style="float: right;">47X-3</span>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>West's Brick Yard</b>  |  |  |  | d. STREET ADDRESS<br><b>1520 A Street, S.E.</b> <span style="float: right;">• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Plummer</b> Last <b></b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>29</b> Year <b>19 59</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>colored</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  | 8. DATE OF BIRTH<br><b>2-18-1900</b>  |  |
| 9. AGE (In years last birthday)<br><b>59 yrs.</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>N. Carolina</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Winslow Plummer</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Matilda Mangrum</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>(If yes, give war or dates of service)</b>   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Address <b>Gertrude Plummer; same address as # 2.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>DUE TO <b>Electrocution</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>   |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Contact with defective cable and ground.</b>                                  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>1.45</b> p.m. <b>6-29-59</b> 19  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>brick yard</b> |  |
| 20f. (City or town)<br><b>Seat pleasant pr. geo. Md.</b>  |  |  |  | 20g. (County) (State)  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>   |  |  |  | DATE SIGNED <b>June 29, 1959</b>   |  |   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>            |  |   |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><b>7-14-59</b>  |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Mem. Cem.</b>   |  | 22d. LOCATION (City, town, or county), Md. (State)<br><b>Prince Geo. Co., Md.</b>           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James &amp; Matthews 3619-14 "St. N.W."</b><br><b>by S. Harris 1326 Wash. D.C.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br><b>JUL 6 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kinn</b>   |  |

MEDICAL CERTIFICATION

2

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Medical District

Home

Age

Place of Birth

Occupation

Sex

Color

Height

Weight

Marital Status

Education

Usual Residence

Usual Occupation

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

Usual Residence

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07116

Reg. Dist. No.

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Washington</b>  |                                   | c. LENGTH OF STAY IN 1b<br><b>6 days</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b> 47X-3   |                                   | d. STREET ADDRESS<br><b>760 Howard Road, S.E.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>9835 Old Fort Road</b>   |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HENRY</b> Middle <b>EDWARD</b> Last <b>PURYEAR</b>  |                                   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>27th</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negree</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH<br><b>August 6th, 1919</b> |
| 9. AGE (In years last birthday)<br><b>39</b> yrs.   |                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Helper</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Moving &amp; Storage</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Boydton, Virginia</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>James Marshall Puryear</b>  |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Fannie Morton</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   |
| 17. INFORMANT<br><b>James M. Puryear, 760 Howard Rd., S.E. Wash. D.C.</b>   |                                   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b><br><b>434.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute congestive heart failure</b><br>DUE TO (c)  |                                   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Poly serositis</b>  |                                   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                   |   |   |
| ACTUAL SIGNATURE<br><b>James I. Boyd</b>  |                                   | DATE SIGNED<br><b>6/27/1959</b>   |   |
| EXAMINER'S NAME (Type)<br><b>James I. Boyd</b>  |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>7-1-59</b>  |                                   | 22b. DATE THEREOF<br><b>Woodlawn</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |                                   | 22d. LOCATION (City, town, or county) (State)<br><b>D.C.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Frederic's Funeral Home, Inc., 389-R. I. Ave. N. W.</b>  |                                   | 24a. REC'D BY REGISTRAR<br><b>JUN 30 '59</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |                                   | DATE  |   |

1968 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

IN MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117

FOR STATE  
HEALTH DEPT.

Reg. Disl. No.

|  |                                  |   |  |   |   |   |                  |
|--|----------------------------------|---|--|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>                     |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Camp Springs</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>20 years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X Camp Springs</u>   |   |   |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>5780 Branch</u>   |                                  |   |  | d. STREET ADDRESS<br><u>15780 Branch Cr</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Wallace</u> Middle <u>Eugene</u> Last <u>Pyles</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>18</u> Year <u>19 59</u>   |   |   |                  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb 28 1879</u> | 9. AGE (In years last birthday)<br><u>80</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>mechanic</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Buildy material</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.-a</u>   |                  |
| 13. FATHER'S NAME<br><u>Wallace Pyles</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Alice Adams</u>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Mr. Cuba V. Pyles, Home as #</u>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br><u>442X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u><br>DUE TO (c)   |                                  |   |  |   |   |   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>322.0 Acute alcoholism</u>   |                                  |   |  |   |   |   |                  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |   |   |   |                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |   |                  |
| ACTUAL SIGNATURE<br><u>James I. Boyd</u>   |                                  |   |  | DATE SIGNED<br><u>June 18, 1959</u>   |   |   |                  |
| EXAMINER'S NAME (Type)<br><u>JAMES I. BOYD</u>   |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>June 20-59</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery, Suitland, Md.</u>   |   | 22d. LOCATION (City, town, or county) (State)   |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Simmons Bros 1661-9th Hope Rd</u>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><u>June 19 59</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>  |                  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

7101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07118

Reg. Dist. No.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                 |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>14 College Park</b>  |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>5009 Lackawanna Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ralph</b> Middle <b>Raymond</b> Last <b>Raynes</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>16,</b> Year <b>1959</b>   |  |   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6-12-1900</b>  |  |   |  |
| 9. AGE (In years last birthday)<br><b>59</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.                                   |  | IF UNDER 24 HRS.<br>Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.  |  |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Captain</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>D.C. Fire Dept.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Indiana</b>                                       |  |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>George Washington Raynes</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Eller</b>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  |   |  |   |  |
| 17. INFORMANT<br><b>Pauline Raynes; same address as # 2.</b>   |  |   |  | Address   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b><br>DUE TO (c)   |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>19</b> o. m. <b>19</b> p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 16, 1959</b>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>6-20-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington D.C.</b>                           |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Thomas B. Naula</b>   |  |   |  | ADDRESS<br><b>3831 Ga. Ave. N.W.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>DATE JUN 19 '59</b>   |  |   |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Orlino S. Hanna</b>  |  |   |  |   |  |

MARRIAGE STATEMENT OF HEALTH - BIRTH RECORD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Date of Death: \_\_\_\_\_

3. Place of Death: \_\_\_\_\_

4. Cause of Death: \_\_\_\_\_

5. Manner of Death: \_\_\_\_\_

6. Age at Death: \_\_\_\_\_

7. Sex: \_\_\_\_\_

8. Race: \_\_\_\_\_

9. Marital Status: \_\_\_\_\_

10. Occupation: \_\_\_\_\_

11. Education: \_\_\_\_\_

12. Religious Beliefs: \_\_\_\_\_

13. Social History: \_\_\_\_\_

14. Family History: \_\_\_\_\_

15. Medical History: \_\_\_\_\_

16. Physical Examination: \_\_\_\_\_

17. Laboratory Tests: \_\_\_\_\_

18. Pathological Findings: \_\_\_\_\_

19. Final Diagnosis: \_\_\_\_\_

20. Signature of Medical Examiner: \_\_\_\_\_

21. Date of Statement: \_\_\_\_\_

TO BE FILLED OUT BY THE MEDICAL EXAMINER  
IN CASE OF DEATH  
TO BE FILLED OUT BY THE MEDICAL EXAMINER  
IN CASE OF MARRIAGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07119

7102

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |   |                                     |
|---|---------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince Georges                         |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cheverly  |                           | c. LENGTH OF STAY IN 1b<br>15 days  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Prince Georges General Hospital   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>William Martin Raynor   |                           | 4. DATE OF DEATH<br>Month Day Year<br>June 18 19 59   |                                     |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Feb. 28th, 1882 |
| 9. AGE (In years lost birthday)<br>77 yrs.  |                           | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Milk Man (Route Salesman)  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Dairy Products   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br>St. Mary's Co., Md.  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                                     |
| 13. FATHER'S NAME<br>Unknown  |                           | 14. MOTHER'S MAIDEN NAME<br>Unknown   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No  |                           | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service)<br>677-14-9906A   |                                     |
| 17. INFORMANT<br>Abraham Raynor, 6130--N--St., Hillside, Md.  |                           | Address   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary embolism<br>DUE TO Arterio-sclerotic heart disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) |                           |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral + Cerebral infarction.   |                           |   |                                     |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br>19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I attended the deceased from June 6, 1959, to June 18, 1959, that I last saw the deceased alive on June 17, 1959, and that death occurred at 7:45 AM, from the causes and on the date stated above.  |                           |   |                                     |
| ACTUAL SIGNATURE<br>Hans Wodak, M.D.  |                           | ADDRESS (Street, city or town, state) DATE SIGNED<br>30-C RIDGE Rd. Greenbelt, Md. 6-19-59  |                                     |
| PHYSICIAN'S NAME (Type)<br>Dr. Hans Wodak, M.D.   |                           |   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>6/20/1959  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Washington Nat'l Cem.   |                           | 22d. LOCATION (City, town, or county) (State)<br>Suitland Rd., Pr. Geo. Co., Md.  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>W.W. Chambers Company, Riverdale, Md.   |                           | 24a. REC'D BY REGISTRAR<br>DATE JUN 22 '59  |                                     |
|   |                           | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |                                     |



# CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                         |  |                                 |
|---|-------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Geo, MARYLAND   |                         | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Md. b. COUNTY PR. GEO.                                 |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Brentwood Md.   |                         | c. LENGTH OF STAY IN 1b<br>58 yrs  |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>4529 Banner st. Md.   |                         | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>34 Brentwood Md  |                                 |
| 3. NAME OF DECEASED<br>(Type or print) RALPH First Middle Last RICHARDSON   |                         | 4. DATE OF DEATH<br>JUNE 8 1959 Month Day Year   |                                 |
| 5. SEX<br>MALE  | 6. COLOR OR RACE<br>COL | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>DEC 16 1889 |
| 9. AGE (In years last birthday)<br>69 yrs.  |                         | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |                         | 10b. KIND OF BUSINESS OR INDUSTRY<br>Porter  |                                 |
| 11. BIRTHPLACE (State or foreign country)<br>Wash. D.C.   |                         | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                 |
| 13. FATHER'S NAME<br>WILLIAM RICHARDSON   |                         | 14. MOTHER'S MAIDEN NAME<br>MILDRED PORTLAND   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No  |                         | 16. SOCIAL SECURITY NO.<br>[blank]   |                                 |
| 17. INFORMANT<br>FERTRUDE BROWN, N. Brentwood   |                         | Address  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HIGH BLOOD PRESSURE<br>(c) ARTERIOSCLEROSIS  |                         | INTERVAL BETWEEN ONSET AND DEATH<br>1955<br>1953<br>1953   |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                         | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY<br>Hour a. 11 p. m. 19  |                         | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                         | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from FEB 21 1959 to JUNE 8 1959 that I last saw the deceased alive on JUNE 8 1959, and that death occurred at 7 P. M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>W. S. Hudson M.D. 509 R. I. Ave NW 6-8-59<br>PHYSICIAN'S NAME (Type) WILLIAM S. HUDSON |                         |  |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                         | 22b. DATE THEREOF<br>6/12/59   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Lincoln mem   |                         | 22d. LOCATION (City, town, or county) (State)<br>Suiland, Ind.   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Henry S. Washington   |                         | ADDRESS<br>467 N. S. St. N.W. W.C.   |                                 |
| 24a. REC'D BY REGISTRAR<br>DATE JUN 11 '59  |                         | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Evans  |                                 |





7059

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Items 1,2 FilmG244 7-2-59 et  
**CERTIFICATE OF DEATH**

07121

Reg. Dist. No.

|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGE CO.</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>CARROLL MANOR</b> b. COUNTY<br><b>47X-3</b>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>6 mo.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Manor Nursing Home</b>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MABEL C RIDGELEY</b>   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 28 1959</b>   |   |
| 5. SEX<br><b>FE</b>   | 6. COLOR OR RACE<br><b>COLORED</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 20, 1879</b>                                |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.   |                                      | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>—</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASH. D.C.</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>FRANCES R COOKE</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>ISABEL OWENS</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                      | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   |
| 17. INFORMANT<br><b>RECORD FROM CARROLL MANOR</b>   |                                      | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROSIS</b><br>DUE TO (c) <b>SENILITY</b>              |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>UREMIA</b>  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1-3</b> , 19 <b>59</b> , to <b>6-27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-27</b> , 19 <b>59</b> , and that death occurred at <b>9:30 A.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>1007 Spring St NW.</b> |                                      |   |   |
| ACTUAL SIGNATURE<br><b>Pinyon L. Cornish</b>  |                                      | M.D. <b>1007 Spring St NW.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>DR. PINYON L. CORNISH</b>   |                                      |   |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><b>7-1-1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Fort Meyer, Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Frederic's Funeral Home, Inc.</b>  |                                      | ADDRESS<br><b>389-R.S. Ave 11th</b>   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 30 '59</b>                       |
|   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>  |   |

090

I

0

1. Nom et adresse du titulaire de la licence

2. Nom et adresse du titulaire de la licence

3. Nom et adresse du titulaire de la licence

4. Nom et adresse du titulaire de la licence

5. Nom et adresse du titulaire de la licence

6. Nom et adresse du titulaire de la licence

7. Nom et adresse du titulaire de la licence

8. Nom et adresse du titulaire de la licence

9. Nom et adresse du titulaire de la licence

10. Nom et adresse du titulaire de la licence

11. Nom et adresse du titulaire de la licence

12. Nom et adresse du titulaire de la licence

13. Nom et adresse du titulaire de la licence

14. Nom et adresse du titulaire de la licence

15. Nom et adresse du titulaire de la licence

16. Nom et adresse du titulaire de la licence

17. Nom et adresse du titulaire de la licence

18. Nom et adresse du titulaire de la licence

19. Nom et adresse du titulaire de la licence

20. Nom et adresse du titulaire de la licence

21. Nom et adresse du titulaire de la licence

22. Nom et adresse du titulaire de la licence

23. Nom et adresse du titulaire de la licence

24. Nom et adresse du titulaire de la licence

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7151

## CERTIFICATE OF DEATH

07122

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George County, MARYLAND</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>Shenandoah</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>10 weeks</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8048 New Fort Washington Rd S.E. Rural</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Hugh</u> First <u>Clifford</u> Middle <u>Rosenberger</u> Last  |  |  |  | 4. DATE OF DEATH <u>June 16</u> 19 <u>59</u>   |  |  |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>W</u>                                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>March 17, 1877</u>                                 |  |
| 9. AGE (In years last birthday) <u>82</u> yrs.  |  | IF UNDER 1 YEAR Months Days                                    |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Toms Brook, Virginia</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Elijah Rosenberger</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Eliz Crabill</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) |  | 17. INFORMANT Address <u>MRS. Louise Cifala, 8048 New Fort Washington Rd S.E.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>450.0 Cardiac De compensation</u><br>DUE TO (b) <u>Bronchopneumonia</u><br>DUE TO (c) <u>Arterio-Sclerosis &amp; Vascular Spasm</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u><br><u>21 days</u><br><u>3 months</u> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>April 15</u> , 19 <u>59</u> , to <u>June 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>59</u> , and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D. <u>7519 Broadview Rd S.E. 6/16/59</u>  |  |  |  | DATE SIGNED <u>June 16, 1959</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd, M.D.</u>  |  |  |  | <u>D.C. 22 (Pr. George County, Md)</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF <u>6/24/59</u>                               |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Toms Brooks</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Woodstock Va</u>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.W. Chambers Co Inc 517 11th St SE</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>June 18 '59</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                      |  |

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7104

Item 7 FilmG244 7-2-59 et

CERTIFICATE OF DEATH

07123

Reg. Dist. No.

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>18 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Rainier</b><br>d. STREET ADDRESS<br><b>3333 Buchanan St.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>John</b><br>Middle<br><b>P</b><br>Last<br><b>Rowles</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>June</b><br>Day<br><b>20</b><br>Year<br><b>19 59</b>  |   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Dec. 12 1889</b> | 9. AGE (In years last birthday)<br><b>69</b> yrs.  | 10. IF UNDER 1 YEAR<br>Months<br><b>6</b><br>Days<br><b>20</b><br>Hours<br><b>12</b><br>Min.<br><b>59</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Black and White Co</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cab Driver</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington D. C.</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |                                  | 13. FATHER'S NAME<br><b>Olevir Duane Rowles</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Estelle Fowler</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>162-1</b>   |   | 17. INFORMANT<br><b>Hospital</b><br>Address<br><b>Cheverly, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia At lary</b><br>DUE TO <b>Broncho pneumonia At lary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Broncho pneumonia At lary</b><br>DUE TO <b>Broncho pneumonia At lary</b><br>(c) <b>Broncho pneumonia At lary</b><br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>162-1</b>   |                                  |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b>12:30A</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>30-C Ridge Rd. Greenbelt Md</b> |   |
| 20f. (City or town)<br><b>Greenbelt</b>  |                                  | 20g. (County)<br><b>Prince George</b>   |   | 20h. (State)<br><b>Md</b>  |   |
| 21. I certify that I attended the deceased from <b>June 18</b> , 19 <b>59</b> , to <b>June 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 19</b> , 19 <b>59</b> , and that death occurred at <b>12:30A</b> M, from the causes and on the date stated above.   |                                  |   |   |  |   |
| ACTUAL SIGNATURE<br><b>Hans Wedak</b>  |                                  | M.D. <b>30-C Ridge Rd. Greenbelt Md</b>   |   | DATE SIGNED<br><b>June 20 1959</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Hans Wedak</b>   |                                  |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>June 23, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATOR<br><b>Fort Lincoln</b>   |   |
| 22d. LOCATION (City, town, or county)<br><b>Colmar Manor, Md.</b>  |                                  | (State)   |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>   |                                  | ADDRESS<br><b>Hyattsville, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>June 29 59</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hines</b>  |                                  |   |   |  |   |

# CERTIFICATE OF DEATH

5104

DECEASED

NAME

SEX

DATE OF BIRTH

AGE

SEX

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME

CAUSE

SEX

AGE

DATE

TIME

CAUSE

SEX

AGE

PLACE OF BIRTH

PLACE OF BIRTH

DATE

TIME

*Handwritten signature and text*

DATE

TIME

CAUSE

SEX

AGE

DATE

TIME

CAUSE

SEX

AGE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7152

## CERTIFICATE OF DEATH

07124

Reg. Dist. No.

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Prince Georges</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>D.C.</b><br>b. COUNTY                               |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (RURAL)</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 months</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Glenn Dale Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Wister Pal Saunders</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 30 1959</b>   |                                    |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/11/08</b> |
| 9. AGE (In years lost birthday)<br><b>51 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Odd jobs</b>  |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |                                    |
| 11c. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Richard Saunders</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Nannie Bowling</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>251-09-8378</b>   |                                    |
| 17. INFORMANT<br><b>Decedent</b>  |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple abscesses of brain, due to Nocardia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonitis with abscess of left upper lobe, due to Nocardia</b><br>DUE TO<br>(c)  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>3 months</b>   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>April 2</b> , 19 <b>59</b> , to <b>June 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>59</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Glenn Dale Hospt., Glenn Dale Md. 6/30/59</b> |                                  |   |                                    |
| ACTUAL SIGNATURE<br><b>MOE WEISS</b><br>PHYSICIAN'S NAME (Type)<br><b>MOE WEISS</b>   |                                  |   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>7/2/59</b>  |                                  | 22b. DATE THEREOF   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>--</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Greenville, S. C.</b>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. E. James Co. 1432 York St. N.W.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>JUL 9 '59</b>   |                                    |
| 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Howard</b>  |                                  |   |                                    |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

7153 <sup>Item 1 Film 244 6-20-59 et</sup> MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07125  
CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                           |  |                                     |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Prince George</i> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY                              |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Murkirk</i>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3Y01-4</i>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private Residence</i>  |                           | d. STREET ADDRESS <i>4704 Idaho Avenue</i>   |                                     |
| 3. NAME OF DECEASED (Type or print) <i>MARY T</i> First Middle Last  |                           | 4. DATE OF DEATH Month <i>JUNE</i> Day <i>20</i> Year <i>19 59</i>   |                                     |
| 5. SEX <i>FEMALE</i>   | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>JULY 4-1875</i> |
| 9. AGE (In years last birthday) <i>83</i> yrs.   |                           | IF UNDER 1 YEAR Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                     |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>   |                           | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |                                     |
| 13. FATHER'S NAME <i>John Krebs</i>  |                           | 14. MOTHER'S MAIDEN NAME <i>Theresa Weber</i>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO.  |                                     |
| 17. INFORMANT Address <i>Mrs. Elizabeth Allenbaugh,</i>  |                           |  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Failure</i><br><i>422.2</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Insufficiency</i><br>(c) <i>Coronary Insufficiency</i> |                           | INTERVAL BETWEEN ONSET AND DEATH   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <i>6-21</i> , 19 <i>59</i> , to <i>6-21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6-21</i> , 19 <i>59</i> , and that death occurred at <i>12:04</i> M, from the causes and on the date stated above.   |                           |  |                                     |
| ACTUAL SIGNATURE <i>Goldo Pierandrei</i> M.D.  |                           | ADDRESS (Street, city or town, state) <i>505 Prince George H. Hall</i>   |                                     |
| PHYSICIAN'S NAME (Type) <i>1 DOLO TIERANDREI M.D.</i>  |                           | DATE SIGNED <i>6/21/59</i> <i>Med.</i>   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                           | 22b. DATE THEREOF <i>6/23/59</i>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>   |                           | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>  |                           | 24a. REC'D BY REGISTRAR DATE <i>JUN 24 '59</i>   |                                     |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kruza</i>  |                           |  |                                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07126

7105

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |  |  |  | c. LENGTH OF STAY IN 1b <b>1 day</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>  |  |  |  | d. STREET ADDRESS <b>Highbridge Rd</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Luther</b> Middle <b>Scruggs</b> Last <b>Scruggs</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>4</b> Year <b>19 59</b>   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1 May 1886</b>   |  |
| 9. AGE (In years last birthday) <b>73</b> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Textile Worker</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Alabama</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <b>James L. Scruggs</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no -</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>no -</b>  |  |  |  |
| 17. INFORMANT <b>James T. Scruggs</b>  |  |  |  | Address <b>Bowie Md</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>(c) <b>Arteriosclerotic Heart Disease</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>5/23</b> , 19 <b>59</b> , to <b>6/4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/3</b> , 19 <b>59</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Frederick Musser</b> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <b>4410 74th Ave</b> DATE SIGNED <b>6/4/59</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. Frederick Musser, M.D.</b>  |  |  |  | <b>Landoner Hills, Md.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>  |  | 22b. DATE THEREOF <b>6/4/59</b>        |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Gadsden</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Alabama</b>                                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>  |  |  |  | 24a. REC'D BY REGISTRAR <b>JUN 8 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |  |

7105

CERTIFICATE OF DEATH

|                       |  |                       |  |                          |  |                            |  |                        |  |
|-----------------------|--|-----------------------|--|--------------------------|--|----------------------------|--|------------------------|--|
| Name of Deceased      |  | Sex                   |  | Age                      |  | Date of Birth              |  | Place of Birth         |  |
| John Doe              |  | Male                  |  | 45                       |  | 1910                       |  | New York               |  |
| Cause of Death        |  | Immediate Cause       |  | Underlying Cause         |  | Manner of Death            |  | Place of Death         |  |
| Heart Disease         |  | Myocardial Infarction |  | Coronary Atherosclerosis |  | Natural                    |  | Home                   |  |
| Date of Death         |  | Time of Death         |  | Place of Death           |  | Physician's Signature      |  | Physician's Title      |  |
| 1955                  |  | 10:00 AM              |  | Home                     |  | [Signature]                |  | MD                     |  |
| Burial or Disposition |  | Place of Burial       |  | Date of Burial           |  | Burial Officer's Signature |  | Burial Officer's Title |  |
| Buried                |  | St. Mary's Cemetery   |  | 1955                     |  | [Signature]                |  | Burial Officer         |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7154 Item 11 Film G243 6-8-59 et  
CERTIFICATE OF DEATH

07127

Reg. Dist. No.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Prince Georges</u> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Seat Pleasant</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>X</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Seat Pleasant</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>524-68th St</u>  |                                  |   | d. STREET ADDRESS<br><u>1 524-68th St</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lula</u> Middle <u>Semo</u> Last <u>Semo</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>3</u> Year <u>1959</u>  |  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb 17, 1896</u>  | 9. AGE (In years lost birthday)<br><u>63</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>South Carolina</u>                                       |  |
| 13. FATHER'S NAME<br><u>Eugene Funderburk</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Amanda Deese</u>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>OTIS Deese</u>  |  | 17. INFORMANT<br><u>519 Addison Rd</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recurrent carcinoma of</u><br><u>171X</u> <u>Abdominal Wall and small Intestines</u><br>DUE TO (b) <u>Cervical carcinoma</u><br>DUE TO (c) <u>Non-Functioning Right Kidney</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Non-Functioning Right Kidney</u>          |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><u>2 1/2 yrs</u>                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                   |  |
| 20f. (City or town)   |                                  | (County)  |  | (State)  |  |
| 21. I certify that I attended the deceased from <u>Feb 19</u> , 19 <u>57</u> , to <u>June 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>59</u> , and that death occurred at <u>2:55 P.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>6001-35th Ave</u> DATE SIGNED <u>6/3/59</u><br>ACTUAL SIGNATURE <u>W.H. Clements</u> M.D.<br>PHYSICIAN'S NAME (Type) <u>Dr. William H. Clements</u> <u>Hyattsville Md</u> |                                  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>June 5, 1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>  |  |
| 22d. LOCATION (City, town, or county)<br><u>Arlington Virginia</u>  |                                  | 22e. (State)<br><u>Virginia</u>   |  | 22f. (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers Co Inc Washington D.C.</u>   |                                  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>JUN 5 '59</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>                                   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07128

7106

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>155002 55th Ave. Hyattsville</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print) <b>Lillian</b> First <b>D.</b> Middle <b>Sidotti</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>4</b> Year <b>1959</b>   |  |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 20, 1913</b> | 9. AGE (In years last birthday)<br><b>45</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington D. C.</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                  | 13. FATHER'S NAME<br><b>Domonic Santaiti</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Fisher</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Horace Sidotti</b> Address <b>Same as # 2</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>410X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral Stenosis</b> DUE TO<br><b>Rheumatic Heart Disease</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b><br><b>20 years</b><br><b>10 years</b> |                                  |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. Month, Day, Year<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town)  |                                  | 20g. (County)   |  | 20h. (State)   |   |
| 21. I certify that I attended the deceased from <b>1947</b> 19 <b>June</b> 19 <b>59</b> , that I last saw the deceased alive on <b>June 2</b> 19 <b>59</b> , and that death occurred at <b>1:30</b> P.M. from the causes and on the date stated above.   |                                  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>Benjamin S. Miller</b><br>M.D.  |                                  | ADDRESS (Street, city or town, state)<br><b>3844 1st Avenue, Hyattsville, Md.</b><br>DATE SIGNED<br><b>June 4, 1959</b>                                     |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Benjamin S. Miller</b>   |                                  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>6/6/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Washington D. C.</b>   |                                  | 22e. (State)<br><b>D. C.</b>  |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>   |                                  | ADDRESS<br><b>Hyattsville, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>DATE JUN 8 '59</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |   |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7155 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

07129

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>   |   | c. LENGTH OF STAY IN 1b <u>2 mo. 1 wk</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Joint Branch Nursing Home</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>James</u> Last <u>Sinclair</u>  |   | 4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>white</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 26, 1868</u> 9. AGE (In years last birthday) <u>90</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |
| 13. FATHER'S NAME <u>James Cameron Sinclair</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Phoebe Mc Gee</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| 17. INFORMANT <u>Nursing Home Records</u>   |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour a. m. _____ p. m. _____<br>Month, Day, Year _____ 19 _____  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) _____ (County) _____ (State) _____                               |
| 21. I certify that I attended the deceased from <u>Apr 17</u> , 19 <u>59</u> , to <u>June 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>59</u> , and that death occurred at <u>6:55 P.</u> M, from the causes and on the date stated above.  |   |  |  |
| ACTUAL SIGNATURE <u>James H. O'Brien</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>2201 Canell Ave</u> DATE SIGNED <u>6-26-59</u>  |  |
| PHYSICIAN'S NAME (Type) <u>Takoma Park Md</u>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>June 29, 1959</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>         |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Canell NW WDC</u>  |   | 24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>   |  |





7156

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07130

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |                             |   |                                   |  |  |   |                                  |
|--|-----------------------------|---|-----------------------------------|--|--|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's • MARYLAND  |                             |   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's |  |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>T. B.  |                             | c. LENGTH OF STAY IN 1b<br>Life   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X T. B.  |  |   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Floral Park Road   |                             |   |                                   | d. STREET ADDRESS<br>Floral Park Road  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print) Harvey Smith   |                             |   |                                   | 4. DATE OF DEATH Month June Day 11, Year 19 59   |  |   |                                  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Dec. 10, 1891 |  | 9. AGE (In years last birthday)<br>67 yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)<br>Laborer  |                             | 10b. KIND OF BUSINESS OR INDUSTRY<br>Farm   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                  |
| 13. FATHER'S NAME<br>Wallace Benjamin Smith  |                             |   |                                   | 14. MOTHER'S MAIDEN NAME<br>Christiana Pinkney   |  |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No   |                             | 16. SOCIAL SECURITY NO.<br>None   |                                   | 17. INFORMANT Address<br>Archie Smith, T. B., Md.  |  |   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute congestive heart failure<br>442X DUE TO<br>Cardiovascular renal disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) |                             |   |                                   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |  |  |   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                             | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |                                  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                 |                             |   |                                   |  |  |   |                                  |
| ACTUAL SIGNATURE James I. Boyd   |                             |   |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED   |                                  |
| EXAMINER'S NAME (Type) James I. Boyd   |                             |   |                                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |                                  |
|  |                             |   |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | June 13, 1959   |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                             | 22b. DATE THEREOF   |                                   | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)   |                                  |
| 6-15-59  |                             | 6-15-59   |                                   | Bethel Cemetery  |  | Brandywine Md   |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |                             |   |                                   | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE  |                                  |
| Hunt Funeral Home Waldorf Md   |                             |   |                                   | JUN 16 '59   |  | Arthur S. Kline   |                                  |

MEDICAL CERTIFICATION

FOR STATE  
DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of Birth: \_\_\_\_\_  
5. Place of Birth: \_\_\_\_\_  
6. Usual Residence: \_\_\_\_\_  
7. Date of Death: \_\_\_\_\_  
8. Time of Death: \_\_\_\_\_  
9. Cause of Death: \_\_\_\_\_  
10. Manner of Death: \_\_\_\_\_  
11. Signature of Medical Examiner: \_\_\_\_\_  
12. Date of Examination: \_\_\_\_\_

Dr. J. C. 29 Battle Avenue  
Harrisburg, Pa.  
1910

FOR STATE  
HEALTH DEPT.

7107

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07131

Reg. Dist. No.

|  |                               |   |                                |
|--|-------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                 |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                               | c. LENGTH OF STAY IN 1b <b>5 hrs</b>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Herman</b> Middle <b>Richard</b> Last <b>Smith</b>   |                               | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>6,</b> Year <b>19 59</b>   |                                |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2-2-17</b> |
| 9. AGE (In years last birthday) <b>42</b> yrs.   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>   |                                |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                |
| 13. FATHER'S NAME <b>James Richard Smith</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Marjorie Elizabeth Windsor</b>  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>579-14-9674</b>  |                                |
| 17. INFORMANT <b>Margaret Elizabeth Smith; same address as # 2.</b>  |                               | Address   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b><br>DUE TO <b>Gunshot wound of head</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>976X</b><br>DUE TO (c)  |                               |   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted gunshot wound</b>                            |                                |
| 20c. TIME OF INJURY<br>Hour <b>2.32</b> o. m. <b>6-6-1959</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>   |                               | 20f. (City or town) <b>Ritchie</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>  |                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |                               |   |                                |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |                               | DATE SIGNED <b>June 6, 1959</b>   |                                |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>9/10/59</b>  |                                |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Wash. Natl. Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) <b>Pr. Geo. Md.</b>   |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Esq.</b>  |                               | 24a. REC'D BY REGISTRAR <b>JUN 9 '59</b>  |                                |
| ADDRESS <b>517 1st St. S.E.</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>  |                                |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7101

FOR 1914

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

TIME OF DEATH: [illegible] SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible] SIGNATURE OF WITNESS: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible]

DATE OF CREMATION: [illegible] PLACE OF CREMATION: [illegible]

DATE OF EXHUMATION: [illegible] PLACE OF EXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF RECREMATION: [illegible] PLACE OF RECREMATION: [illegible]

DATE OF REEXHUMATION: [illegible] PLACE OF REEXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF RECREMATION: [illegible] PLACE OF RECREMATION: [illegible]

DATE OF REEXHUMATION: [illegible] PLACE OF REEXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF RECREMATION: [illegible] PLACE OF RECREMATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7157

## CERTIFICATE OF DEATH

07132

Reg. Dist. No.

|  |                           |  |                                       |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>        |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HYATTSVILLE</u>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HYATTSVILLE</u>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1801 CHILLUM RD</u>  |                           | d. STREET ADDRESS <u>1801 CHILLUM RD</u>   |                                       |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |                                       |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND JENNINGS SOUDER</u>   |                           | 4. DATE OF DEATH Month Day Year <u>JUNE 8 1959</u>   |                                       |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 27, 1896</u> |
| 9. AGE (In years lost birthday) <u>62</u> yrs.   |                           | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>CAP TEL Co</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                       |
| 13. FATHER'S NAME <u>LEWIS FRANCIS SOUDER</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>MARGARET LANHARDT</u>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO. <u>GEORGE SOUDER</u>   |                                       |
| 17. INFORMANT Address <u>HYATTSVILLE, Md.</u>  |                           |  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO (c) <u>1 YEAR</u>  |                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 DAY</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>59</u> , to <u>JUNE 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 8</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>4300 KAYWOOD DRIVE MT RAINIER, Md.</u><br>DATE SIGNED <u>JUNE 8, 1959</u><br>ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u> M.D.<br>PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u> |                           |  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                           | 22b. DATE THEREOF <u>6/11/59</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>  |                           | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>  |                           | 24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>   |                                       |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>  |                           |  |                                       |

MEDICAL CERTIFICATION

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7108

CERTIFICATE OF DEATH

07133

Reg. Dist. No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>7 hours</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince Georges General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Ida k. Sprague</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 10 1959</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1/27/02 1901</b> |
| 9. AGE (In years lost birthday)<br><b>58 5/7</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 12. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 13. FATHER'S NAME<br><b>Fred Stuehm</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Kruger</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Raymond E. Sprague</b><br><b>Raymond Husband</b>   |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>410X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Unicase Stear's (Rheumatic Arthritis)</b><br>DUE TO (c) |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1953</b> , to <b>6-10-1959</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>59</b> , and that death occurred at <b>10:04 PM</b> , from the causes and on the date stated above. |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Albert Roth</b>   |                                  | DATE SIGNED<br><b>6-11-59</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. A Roth M.D.</b>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>6/15/59</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Va.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>June 15 '59</b>   |   |
| ADDRESS<br><b>Hyattsville, Maryland</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |   |

CERTIFICATE OF DEATH

7108

|                  |  |                |  |                     |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |
|------------------|--|----------------|--|---------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased |  | Sex            |  | Age                 |  | Date of Birth          |  | Place of Birth         |  | Usual Residence        |  | Cause of Death         |  | Date of Death          |  | Time of Death          |  | Place of Death         |  | Signature of Physician |  | Signature of Registrar |  |
| John Doe         |  | Male           |  | 45                  |  | Jan 15 1925            |  | New York City          |  | New York City          |  | Heart Disease          |  | Jan 15 1970            |  | 10:00 AM               |  | St. Mary's Hospital    |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  |
| Occupation       |  | Marital Status |  | Education           |  | Religion               |  | Race                   |  | Color                  |  | Manner of Death        |  | Certified by           |  | Date                   |  | Signature              |  | Signature              |  | Signature              |  |
| Teacher          |  | Married        |  | High School         |  | Catholic               |  | White                  |  | White                  |  | Natural                |  | J. A. Smith, M.D.      |  | Jan 15 1970            |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. C. Doe, Physician   |  |
| Date of Death    |  | Time of Death  |  | Place of Death      |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  |
| Jan 15 1970      |  | 10:00 AM       |  | St. Mary's Hospital |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  |
| Cause of Death   |  | Date of Death  |  | Time of Death       |  | Place of Death         |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  |
| Heart Disease    |  | Jan 15 1970    |  | 10:00 AM            |  | St. Mary's Hospital    |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  |
| Date of Death    |  | Time of Death  |  | Place of Death      |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  |
| Jan 15 1970      |  | 10:00 AM       |  | St. Mary's Hospital |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  |
| Cause of Death   |  | Date of Death  |  | Time of Death       |  | Place of Death         |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  |
| Heart Disease    |  | Jan 15 1970    |  | 10:00 AM            |  | St. Mary's Hospital    |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  | J. A. Smith, M.D.      |  | J. B. Jones, Registrar |  |

7060

Item 9 Film G244 7/9/59 cap

CERTIFICATE OF DEATH

07134

Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville, Md.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wash. D.C. 47x-3</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Carroll Manor 4922 La Salle Rd</u>  |   | d. STREET ADDRESS<br><u>2225 N. St. N. W.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Marie</u> Middle <u>A</u> Last <u>Springirth</u>   |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>26</u> Year <u>1959</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH<br><u>Nov. 11, 1871</u>                        |
| 9. AGE (In years last birthday)<br><u>87 1/2</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Red Cross</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Wash. D.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Reinhold Springirth</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Marie Klinner</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) (If yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO. <u>  </u> INFORMANT <u>Dr. M. Bernadette Jugh</u> Address <u>Carroll Manor 4922 La Salle Rd.</u>                                       |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory depression</u><br>DUE TO <u>Cerebral vascular accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arterio sclerosis</u><br>DUE TO (b) <u>  </u><br>(c) <u>  </u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>years</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial intestinal obstruction dueto ileus</u>  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>6/21</u> , 19 <u>59</u> , to <u>6/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/26</u> , 19 <u>59</u> , and that death occurred at <u>12:47</u> A.M., from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D. <u>4323 Harvard St. S.E. Spg., Md.</u>   |   | ADDRESS (Street, city or town, state) DATE SIGNED  |   |
| PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY</u>  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>June 29 '59</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Prospect Hill</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Wash DC</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>DEVO FUNERAL HOME</u>   |   | ADDRESS<br><u>WASH. D.C.</u>   |   |
| 24a. REC'D BY REGISTRAR<br><u>AUG 6 '59</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Charles S. Kraus</u>  |   |

10110

CERTIFICATE OF MARRIAGE

10110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07135

7109

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> D.C. b. COUNTY <b>Prince Georges</b> -- ✓ |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10 hrs</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby</b> Middle <b>Boy</b> Last <b>Stallings</b>  |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7</b> Year <b>19 59</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>6 June 1959</b> |
| 9. AGE (In years last birthday)<br><b>10</b>  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Donald Stallings</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Taylor</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>None</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Mother</b>  |  |
| 17. INFORMANT<br><b>Mother</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis</b><br>762.5 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mediastinal emphysema</b><br>DUE TO (c) <b>Prematurity</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hr</b><br><b>10 hr</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>6/6</b> , 19 <b>57</b> , to <b>6/7</b> , 19 <b>57</b> ; that I last saw the deceased alive on <b>6/7</b> , 19 <b>57</b> , and that death occurred at <b>6,10 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED             |                                  |   |  |
| ACTUAL SIGNATURE <b>John R. Kehoe</b> M.D.  |                                  |   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe., MdD.</b>  |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>   |                                  | 22b. DATE THEREOF<br><b>6/11/59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Prince George's General Hospital, Cheverly, Md.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harry W Penn, Jr.</b><br>Administrator.  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 18 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kenna</b>  |                                  |   |  |

01163

CERTIFICATE OF DEATH

2018

IN BOND

|                                 |  |                             |  |                                   |  |                           |  |                            |  |
|---------------------------------|--|-----------------------------|--|-----------------------------------|--|---------------------------|--|----------------------------|--|
| 1. Name of Deceased             |  | 2. Sex                      |  | 3. Race                           |  | 4. Date of Birth          |  | 5. Date of Death           |  |
| 6. Place of Birth               |  | 7. Usual Residence          |  | 8. Cause of Death                 |  | 9. Manner of Death        |  | 10. Signature of Physician |  |
| 11. Signature of Registrar      |  | 12. Signature of Informant  |  | 13. Signature of Medical Examiner |  | 14. Signature of Coroner  |  | 15. Signature of Jury      |  |
| 16. Signature of Burial Officer |  | 17. Signature of Undertaker |  | 18. Signature of Funeral Home     |  | 19. Signature of Cemetery |  | 20. Signature of Burial    |  |
| 21. Signature of Interment      |  | 22. Signature of Burial     |  | 23. Signature of Burial           |  | 24. Signature of Burial   |  | 25. Signature of Burial    |  |
| 26. Signature of Burial         |  | 27. Signature of Burial     |  | 28. Signature of Burial           |  | 29. Signature of Burial   |  | 30. Signature of Burial    |  |
| 31. Signature of Burial         |  | 32. Signature of Burial     |  | 33. Signature of Burial           |  | 34. Signature of Burial   |  | 35. Signature of Burial    |  |
| 36. Signature of Burial         |  | 37. Signature of Burial     |  | 38. Signature of Burial           |  | 39. Signature of Burial   |  | 40. Signature of Burial    |  |
| 41. Signature of Burial         |  | 42. Signature of Burial     |  | 43. Signature of Burial           |  | 44. Signature of Burial   |  | 45. Signature of Burial    |  |
| 46. Signature of Burial         |  | 47. Signature of Burial     |  | 48. Signature of Burial           |  | 49. Signature of Burial   |  | 50. Signature of Burial    |  |
| 51. Signature of Burial         |  | 52. Signature of Burial     |  | 53. Signature of Burial           |  | 54. Signature of Burial   |  | 55. Signature of Burial    |  |
| 56. Signature of Burial         |  | 57. Signature of Burial     |  | 58. Signature of Burial           |  | 59. Signature of Burial   |  | 60. Signature of Burial    |  |
| 61. Signature of Burial         |  | 62. Signature of Burial     |  | 63. Signature of Burial           |  | 64. Signature of Burial   |  | 65. Signature of Burial    |  |
| 66. Signature of Burial         |  | 67. Signature of Burial     |  | 68. Signature of Burial           |  | 69. Signature of Burial   |  | 70. Signature of Burial    |  |
| 71. Signature of Burial         |  | 72. Signature of Burial     |  | 73. Signature of Burial           |  | 74. Signature of Burial   |  | 75. Signature of Burial    |  |
| 76. Signature of Burial         |  | 77. Signature of Burial     |  | 78. Signature of Burial           |  | 79. Signature of Burial   |  | 80. Signature of Burial    |  |
| 81. Signature of Burial         |  | 82. Signature of Burial     |  | 83. Signature of Burial           |  | 84. Signature of Burial   |  | 85. Signature of Burial    |  |
| 86. Signature of Burial         |  | 87. Signature of Burial     |  | 88. Signature of Burial           |  | 89. Signature of Burial   |  | 90. Signature of Burial    |  |
| 91. Signature of Burial         |  | 92. Signature of Burial     |  | 93. Signature of Burial           |  | 94. Signature of Burial   |  | 95. Signature of Burial    |  |
| 96. Signature of Burial         |  | 97. Signature of Burial     |  | 98. Signature of Burial           |  | 99. Signature of Burial   |  | 100. Signature of Burial   |  |

Vertical text on the right margin, likely a filing or tracking number.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07136

7110

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b><br><b>Cheverly</b>  |  | b. CITY OR TOWN (If outside corporate limits, write Rural or nearest town) |  | c. LENGTH OF STAY IN 1b<br><b>1 MO. 17 Days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George's</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>   |  |  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Margaret</b>  |  | First<br><b>V.</b>   |  | Middle<br><b>Starr</b>  |  | 4. DATE OF DEATH<br>Month<br><b>June 23</b><br>Day<br><b>19</b><br>Year<br><b>59</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 5, 1922</b>   |  | 9. AGE (In years last birthday)<br><b>36</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Odd jobs</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                           |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Paul Starzycki</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Victoria Werynski</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>118-18-8516</b>                              |  | 17. INFORMANT<br><b>Wanda H. Starr, 537--84th St., Brooklyn, N.Y.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Indistinct abstract</b><br><b>174X</b> DUE TO <b>Generalized Carcinomatosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of abdomen Ca when</b><br>DUE TO (c) <b>2 years</b>   |  |  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour<br>p. m.<br>Month, Day, Year<br><b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)  |  |
| 21. I certify that I attended the deceased from <b>May 6</b> , 19 <b>59</b> to <b>June 23</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 23</b> , 19 <b>59</b> and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED<br>ACTUAL SIGNATURE <b>Dayton Watkins</b> M.D. <b>5304 Annapolis Rd 6-23-59</b><br>PHYSICIAN'S NAME (Type) <b>DAYTON O WATKINS Bladensburg Md</b> |  |  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>6/26/1959</b>                                      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Nat'L Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland Rd. Pr. Geo. Co., Md.</b>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Company, Riverdale, Md.</b>   |  |  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 29 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

0131

100

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

SOCIETY AND ENVIRONMENT

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4  
should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

7062

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07138

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Transient</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sligo Creek Parkway</b>  |                                  | e. STREET ADDRESS<br><b>5905 Crawford Drive</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Thomas Bernard Stickley</b>  |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>25</b> Year <b>19 59</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>September 16, '25</b> 33 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Service Manager</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Sewing Machine</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas B. Stickley</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Mae Howser</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b><br>(If yes, give war or dates of service) <b>Mer. Marine</b>   |                                  | 16. SOCIAL SECURITY NO. <b>215-20-6440</b>   |  |
| 17. INFORMANT<br><b>Ruth Ann Stickley; same address as # 2</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br><b>822X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Universal burns of body</b><br>(a), stating the underlying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Operator of a jeep which turned over and caught fire.</b> |  |
| 20c. TIME OF INJURY<br>Hour <b>3:40</b> a.m. <b>6-25-1959</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>  |                                  | 20f. (City or town) (County) (State)<br><b>Takoma Park Pr. Geo. Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                                  |  |  |
| ACTUAL SIGNATURE<br><b>John T. Maloney</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>John T. Maloney, M.D.</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>6/27/59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                  | ADDRESS<br><b>Bethesda, Maryland</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>JUN 29 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hanna</b>   |  |

MEDICAL CERTIFICATION

16

2

M

I

2

16

FOR WALK  
HEALTH DEPT

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| NAME OF DECEASED<br><b>John A. Roberts</b>            |  | AGE<br><b>35</b>                       |  | SEX<br><b>Male</b>                     |  |
| RACE<br><b>White</b>                                  |  | DATE OF DEATH<br><b>June 22, 1933</b>  |  | PLACE OF DEATH<br><b>Home</b>          |  |
| RESIDENCE<br><b>1234 North Avenue</b>                 |  | CITY<br><b>Baltimore</b>               |  | COUNTY<br><b>Harford</b>               |  |
| OCCUPATION<br><b>Electrician</b>                      |  | CAUSE OF DEATH<br><b>Heart Disease</b> |  | MANNER OF DEATH<br><b>Natural</b>      |  |
| PREVIOUS ILLNESS<br><b>None</b>                       |  | SIGNS AND SYMPTOMS<br><b>None</b>      |  | POST-MORTEM EXAMINATION<br><b>None</b> |  |
| FAMILY HISTORY<br><b>None</b>                         |  | SOCIAL HISTORY<br><b>None</b>          |  | HISTORICAL DATA<br><b>None</b>         |  |
| PHYSICAL EXAMINATION<br><b>None</b>                   |  | LABORATORY EXAMINATION<br><b>None</b>  |  | PATHOLOGICAL FINDINGS<br><b>None</b>   |  |
| DIAGNOSIS<br><b>Heart Disease</b>                     |  | TREATMENT<br><b>None</b>               |  | PROGNOSIS<br><b>None</b>               |  |
| SIGNATURE OF EXAMINER<br><b>John A. Roberts</b>       |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF WITNESS<br><b>John A. Roberts</b>        |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF CORONER<br><b>John A. Roberts</b>        |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF JURY<br><b>John A. Roberts</b>           |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF JUDGE<br><b>John A. Roberts</b>          |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF CLERK<br><b>John A. Roberts</b>          |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF SHERIFF<br><b>John A. Roberts</b>        |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF DEPUTY SHERIFF<br><b>John A. Roberts</b> |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF CONSTABLE<br><b>John A. Roberts</b>      |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF JURY<br><b>John A. Roberts</b>           |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF JUDGE<br><b>John A. Roberts</b>          |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF CLERK<br><b>John A. Roberts</b>          |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF SHERIFF<br><b>John A. Roberts</b>        |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF DEPUTY SHERIFF<br><b>John A. Roberts</b> |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |
| SIGNATURE OF CONSTABLE<br><b>John A. Roberts</b>      |  | DATE<br><b>June 22, 1933</b>           |  | PLACE<br><b>Home</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7111

## CERTIFICATE OF DEATH

07139

Reg. Dist. No.

|  |                               |  |                                |
|--|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George County</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>              |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b>   |                                |
| c. LENGTH OF STAY IN 1b <b>5 Days</b>  |                               | d. STREET ADDRESS <b>7513 Forest Rd</b>  |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |
| 3. NAME OF DECEASED (Type or print) <b>SWANEY, Andrew H Sweeney</b>  |                               | 4. DATE OF DEATH <b>June 15 1959</b>   |                                |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>7/7/23</b> |
| 9. AGE (In years last birthday) <b>35</b>  |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Greenkeeper</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Country Club</b>  |                                |
| 11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |                                |
| 13. FATHER'S NAME <b>S Andrew Sweeney</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Louise Howard</b>  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W W 11</b>   |                               | 16. SOCIAL SECURITY NO. <b>Margaret A Sweeney Kentland, Md.</b>  |                                |
| 17. INFORMANT <b>Margaret A Sweeney</b>  |                               | Address  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic failure</b><br>581.0 DUE TO <b>Fatty metamorphosis of the liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)   |                               |  |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that I attended the deceased from <b>June 11, 1959</b> to <b>June 15, 1959</b> , that I last saw the deceased alive on <b>June 15, 1959</b> and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>5304 Annapolis Road</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>William D. Rosson MD</b><br>PHYSICIAN'S NAME (Type) <b>William D. Rosson MD</b> <b>Bladensburg, Maryland</b> |                               |  |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>6/19/59</b>   |                                |
| 22c. NAME OF CEMETERY OR INTERMENT <b>Arlington National</b>   |                               | 22d. LOCATION (City, town, county) (State) <b>Arlington</b>  |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Maryland.</b>   |                               | 24a. REC'D BY REGISTRAR <b>JUN 22 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>   |                                |

CERTIFICATE OF DEATH

7111

and fill in

|  |  |   |  |
|--|--|---|--|
| <p>1. Name of deceased: <i>John Doe</i></p>          |  | <p>2. Sex: <i>Male</i></p>                              |  |
| <p>3. Date of birth: <i>Jan 1, 1900</i></p>          |  | <p>4. Date of death: <i>Jan 1, 1950</i></p>             |  |
| <p>5. Place of birth: <i>Baltimore, Md.</i></p>      |  | <p>6. Place of death: <i>Baltimore, Md.</i></p>         |  |
| <p>7. Cause of death: <i>Heart Disease</i></p>       |  | <p>8. Immediate cause: <i>Myocardial Infarction</i></p> |  |
| <p>9. Duration of illness: <i>2 weeks</i></p>        |  | <p>10. Usual place of abode: <i>Home</i></p>            |  |
| <p>11. Name of physician: <i>Dr. J. H. Smith</i></p> |  | <p>12. Name of funeral director: <i>John Doe</i></p>    |  |
| <p>13. Name of informant: <i>John Doe</i></p>        |  | <p>14. Signature of informant: <i>[Signature]</i></p>   |  |
| <p>15. Name of registrar: <i>John Doe</i></p>        |  | <p>16. Signature of registrar: <i>[Signature]</i></p>   |  |

1



7061

CERTIFICATE OF DEATH

07140

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>PRINCE GEORGES</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>WASH. D.C.</u> b. COUNTY                            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HYATTSVILLE</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u> <u>47X-3</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>HYATTSVILLE CONVALESCENT REST HOME</u>  |  |  |  | d. STREET ADDRESS<br><u>2941 MILLS AVE. N. E.</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>KATHERINE</u> First <u>SWITZER</u> Middle Last  |  |  |  | 4. DATE OF DEATH <u>JUNE</u> Month <u>10</u> Day <u>1959</u> Year  |  |  |  |
| 5. SEX <u>FE</u>   |  | 6. COLOR OR RACE <u>W</u>                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Aug. 22 - 1890</u>                                     |  |
|  |  |  |  | 9. AGE (In years last birthday) <u>68</u> yrs.   |  | 10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NURSE</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>U.S.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 13. FATHER'S NAME<br><u>HENRY MILLER</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>HELEN GRAY</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT <u>DAUGHTER</u> Address<br><u>MARGARET BELLAMY - 2941 MILLS AVE. N.E.</u>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>Cerebral Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u></u><br>DUE TO <u></u><br>(c) <u></u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>72 HRS.</u><br><u>2 YRS</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  |
|  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>MAY 15, 1958</u> , to <u>JUNE 9, 1959</u> , that I last saw the deceased alive on <u>JUNE 10, 1959</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Herbert G. Brandes</u> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <u>400 W ST. N.E. - D.C.</u> DATE SIGNED <u>6/10</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>HERBERT G. BRANDES</u>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |  | 22b. DATE THEREOF<br><u>June 13 - 1959</u> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Wooden Hill</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>W.D. Scotland, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J J Postells</u>  |  |  |  | ADDRESS<br><u>1722 - North Cap. U.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUN 12 '59</u>                          |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Hanes</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 7112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G244 6-19-59 et

07141

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 N. Brentwood</b>  |  |   |  |
| c. LENGTH OF STAY IN 1b <b>D.O.A.</b>  |  |  |  | d. STREET ADDRESS <b>4537 41st Avenue</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>William Henry Thomas</b>  |  |  |  | 4. DATE OF DEATH Month Day Year <b>June 7, 19 59</b>   |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>colored</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Oct. 15, 1879</b>   |  |
| 9. AGE (in years last birthday) <b>80 79rs.</b>  |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Porter</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>                       |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <b>John Harry Thomas</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Annie Randall</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <b>Hattie Belle Thomas; same address as # 2.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b><br>(a), stating the underlying cause last. DUE TO (c)   |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Endarteritis obliterans Senility</b>  |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 7, 1959</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>June 11, 1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>4611 Benning Rd., S.E. Wash., D.C.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Malven &amp; Schey, Inc. 424 "R" St., N. W.</b>  |  |  |  | 24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Continued S. Kraus</b>                                    |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07142

7113

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George</b>      |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chesverly</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10 days</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Prince George General</b>   |                                  | d. STREET ADDRESS<br><b>3602 Perry St</b>   |                                       |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Antonio Toffon</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 3 1959</b>  |                                       |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug 2 1889</b> |
| 9. AGE (In years last birthday)<br><b>69 yrs.</b>  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Bassano, Italy</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME<br><b>Luga Toffon</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Geola Dominica</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |                                       |
| 17. INFORMANT<br><b>Son</b>  |                                  | Address<br><b>Alfred Toffon, 8607 22Nd, Adelphi, Md.</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LARYNX</b><br><b>161X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>WITH METASTASES</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mos</b> |                                  |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>June 1953</b> , to <b>June 3 1959</b> , that I last saw the deceased alive on <b>June 3 1959</b> , and that death occurred at <b>2:35 P. M.</b> from the causes and on the date stated above.   |                                  |   |                                       |
| ACTUAL SIGNATURE<br><b>Norman D. Comeau</b>  |                                  | DATE SIGNED<br><b>6/3/59</b>  |                                       |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Norman Comeau</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>3503 Perry St. Mt Rainier Md</b>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>6/6/59</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, DC</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Valley's Funeral Home Inc.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 10 '59</b>   |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |                                  |   |                                       |

CERTIFICATE OF DEATH

1113

|                        |  |                       |  |                          |  |                        |  |                        |  |
|------------------------|--|-----------------------|--|--------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased       |  | Sex                   |  | Age                      |  | Date of Death          |  | Place of Death         |  |
| John Doe               |  | Male                  |  | 45                       |  | Jan 15, 1950           |  | Home                   |  |
| Cause of Death         |  | Immediate Cause       |  | Underlying Cause         |  | Manner of Death        |  | Occupation             |  |
| Heart Disease          |  | Myocardial Infarction |  | Coronary Atherosclerosis |  | Natural                |  | Teacher                |  |
| Date of Birth          |  | Place of Birth        |  | Marital Status           |  | Usual Residence        |  | Signature of Physician |  |
| Jan 1, 1905            |  | New York City         |  | Married                  |  | 123 Main St, Baltimore |  | [Signature]            |  |
| Signature of Registrar |  | Name of Registrar     |  | Title of Registrar       |  | Date of Registration   |  | Official Seal          |  |
| [Signature]            |  | John Doe              |  | Registrar                |  | Jan 16, 1950           |  | [Seal]                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07143

7158

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGE</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEO.</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORESTVILLE</b>   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X SUITLAND</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>FORESTVILLE NURSING HOME</b>  |  |   |  | d. STREET ADDRESS<br><b>4640 LACY AVE.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANNIE</b> Middle <b>JORDON</b> Last <b>ULRICH</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>6TH</b> Year <b>1959</b>   |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>MAY 16TH 1869</b>  |  |
| 9. AGE (In years last birthday)<br><b>90</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                       |  | 11. BIRTHPLACE (State or foreign country)<br><b>KINGWOOD W. VA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give year or dates of service)<br><b>NONE UNKNOWN</b> |  | 17. INFORMANT<br><b>MABEL T. GRAHAM</b> Address <b>4640 LACY AVE SUITLAND MD</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b><br>DUE TO (c) |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hr</b><br><b>10 yrs</b>                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day, Year 19  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>June 10, 1959</b> to <b>June 6, 1959</b> , that I last saw the deceased alive on <b>June 5, 1959</b> , and that death occurred at <b>5 PM</b> M, from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>R. C. Kirchner</b>  |  |   |  | M.D. <b>6480 N. N. Ave</b>  |  | DATE SIGNED<br><b>6/6/59</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>R. C. KIRCHNER</b>   |  |   |  | <b>TAKOMA PARK MD</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify)  |  | 22b. DATE THEREOF<br><b>6/9/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Wash. Mt. Mem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland Md</b>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. Chamber Co. 517 11th St. S.E.</b>   |  |   |  | ADDRESS<br><b>517 11th St. S.E.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 9 '59</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7159

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07144

Reg. Dist. No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Prince George's</i> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>District of Columbia</i> b. COUNTY <i>Col umbia</i> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenn Dale</i>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>   |   |
| c. LENGTH OF STAY IN 1b <i>4 yrs 3 mos</i>  |                                  | 47X-3  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glenn Dale Hosp.</i>  |                                  | d. STREET ADDRESS <i>2615 12th Pl. S.E.</i>  |   |
| 3. NAME OF DECEASED (Type or print) <i>JAMES</i> First <i>M.</i> Middle <i>WEEMS</i> Last   |                                  | 4. DATE OF DEATH Month <i>6</i> Day <i>21</i> Year <i>1959</i>   |   |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>N</i>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/28/98</i>   |
| 9. AGE (In years lost birthday) <i>60</i> yrs.  |                                  | 10. FUNDING YEAR IF UNDER 24 HRS. Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Order</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Bldg. Maint.</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |   |
| 13. FATHER'S NAME <i>William Weems</i>  |                                  | 14. MOTHER'S MAIDEN NAME <i>Fiza Berry</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO. <i>none</i>  |   |
| 17. INFORMANT <i>Deceased</i>   |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage</i><br>DUE TO <i>Pulmonary tuberculosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i><br><i>4 yrs 5 mos.</i>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <i>3/21</i> , 19 <i>55</i> , to <i>6/21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/21</i> , 19 <i>59</i> , and that death occurred at <i>6:50</i> A.M., from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <i>MOE WEISS</i> M.D.  |                                  | ADDRESS (Street, city or town, state) <i>Glenn Dale Hosp.</i> DATE SIGNED <i>6/21/59</i>   |   |
| PHYSICIAN'S NAME (Type) <i>MOE WEISS M.D.</i>   |                                  | <i>Glenn Dale, Md.</i>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>  | 22b. DATE THEREOF <i>6/21/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem. Cemetery</i>  | 22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Marion Funeral Home</i> ADDRESS <i>1500 Nichols Ave S.E.</i>  |                                  | 24a. REC'D BY REGISTRAR <i>Robt. E. Anderson</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>  |   |

Robt. E. Anderson (A 340)

# CERTIFICATE OF DEATH

TO HOSPITAL ( )  
may be retained  
TO FUNERAL D.  
page 3 should

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death by the hospital or attending physician.

**(OR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

death: Page 4

7114

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G245 7-28-59 et

## CERTIFICATE OF DEATH

07145

Reg. Dist. No.

|  |                                  |   |   |   |  |   |   |
|--|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>21 days</b> |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>15 Hyattsville</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |                                  |   |   | d. STREET ADDRESS<br><b>4715 41st Place</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Issac</b> Middle <b>Wheeler</b> Last <b>Wheeler</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>30</b> Year <b>19 59</b>   |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Black</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>MARCH 4 - 1894</b>   |  | 9. AGE (In years last birthday) yrs. <b>65</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chef</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   |
| 13. FATHER'S NAME<br><b>Oscar J. Wheeler</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Bell Hawkins</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>W. W. I</b>   |   | 17. INFORMANT<br><b>Mary - Wife</b>   |  | Address<br><b>Address Same</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic heart disease</b><br>DUE TO (c) <b>Unknown</b> |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>21 days</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>6/9</b> , 19 <b>59</b> , to <b>6/30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/30</b> , 19 <b>59</b> , and that death occurred at <b>6.25 AM</b> , from the causes and on the date stated above.   |                                  |   |   |   |  |   |   |
| ACTUAL SIGNATURE <b>Julius Kauffman</b> M.D.   |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>5102 Annap. Rd. Bladensburg, Md.</b>  |  | DATE SIGNED<br><b>6/30/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. J. Kauffman., M.D.</b>  |                                  |   |   |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)   |   |
| <b>Burial</b>  |                                  | <b>7-2-59</b>   |   | <b>Arlington Nat.</b>   |  | <b>75 Myer, Va.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hall Bros, 621 Fla. Ave. N.W.</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 6 59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Frank</b>  |   |

MEDICAL CERTIFICATION

the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7115

CERTIFICATE OF DEATH

Reg. Dist. No.

07146

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Choverly</b>   |                                  | c. LENGTH OF STAY IN 1b <b>4 day</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Roland</b> Middle <b>G</b> Last <b>White</b>   |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>13</b> Year <b>19 59</b>  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6 Nov 1894</b>                                       |
| 9. AGE (In years last birthday) <b>64</b> yrs.   |                                  | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman (railroad)</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Terminal</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>George Eldridge White</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Mollie E. Howes</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO. <b>yes</b>   |  |
| 17. INFORMANT <b>Mrs. Anna H. White, 3710 Hamilton St.</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>A.S.H.D. Plumonary infarction</b><br>DUE TO<br>(c) <b>Coronary thrombosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo</b><br><b>6.mo.</b><br><b>3 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary thrombosis</b>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>19 56</b> , to <b>June 13 59</b> , that I last saw the deceased alive on <b>13 June 19 59</b> , and that death occurred at <b>4.10 AM</b> , from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <b>Samuel J Sugar</b> M.D.  |                                  | ADDRESS (Street, city or town, state) <b>4300 Raywood Drive</b> DATE SIGNED <b>6/13/59</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Samuel J Sugar, M.D.</b>  |                                  | <b>Mr Raimen, Jr</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 22b. DATE THEREOF <b>6/15/59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>COLUMBIA GARDENS CEMETERY</b>  | 22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, INC.</b> ADDRESS <b>SILVER SPRING, MO.</b>  |                                  | 24a. REC'D BY REGISTRAR <b>DATE JUN 16 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>  |                                  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

7063

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

07147

|   |                               |  |  |  |  |   |  |
|---|-------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Prince Georges</u> MARYLAND   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>P.R.G.</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 3 yrs.  |                               |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>                                  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7906 Lockney Ave.</u>   |                               |  |  | d. STREET ADDRESS <u>17906 LOCKNEY, AVE.</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Claus John M Wilkens</u>   |                               |  | 4. DATE OF DEATH Month Day Year <u>June 7th 1959</u> |  |  |   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 7, 1874</u>                |  | 9. AGE (In years last birthday) <u>85</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min.  | IF UNDER 24 HRS. Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Germany</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Claus Wilkens Sr.</u>  |                               |  | 14. MOTHER'S MAIDEN NAME <u>Sophia Haass</u>         |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT Address <u>Henry F. Wilkens, Maryland, Delaware</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with</u><br><u>332x</u> DUE TO <u>Hemiplegia, right side</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>19 days</u><br>DUE TO (c) |                               |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pyelonephritis</u>   |                               |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>May 20, 1959</u> to <u>June 7, 1959</u> , that I last saw the deceased alive on <u>June 5, 1959</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.  |                               |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Wallace N. Mook, M.D.</u>   |                               |  |  | ADDRESS (Street, city or town, state) <u>7701 Carroll Avenue</u> DATE SIGNED <u>6/7/59</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Wallace N. Mook, MD</u>  |                               |  |  | <u>Takoma Park 12, Md.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>6-10-59</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Old Yellowz</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Camden, Del.</u>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Esham, Jr.</u> ADDRESS <u>Georgetown, Del.</u>   |                               |  |  | 24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knecht</u>                                  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Registrar's Office notified and approved  
issuance of Certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7116

CERTIFICATE OF DEATH

07148

Reg. Dist. No.

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George's</u> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Pr George's</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>  |                                 | c. LENGTH OF STAY IN 1b <u>15 min</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's Co. Hosp.</u>  |                                 | d. STREET ADDRESS <u>801 Eastern Ave</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>WOOLFOLK</u> Middle Last   |                                 | 4. DATE OF DEATH <u>June 13</u> Month Day Year <u>1959</u>   |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 15, 1887</u> AGE (In years last birthday) <u>72</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editorial Writer Nat Geographic Soc.</u>  |                                 | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  |
| 13. FATHER'S NAME <u>WOOLFOLK</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>MARY CRUTCHFIELD</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                                 | 16. SOCIAL SECURITY NO. <u>579-48-845</u>  |  |
| 17. INFORMANT <u>LEONARD H WOOLFOLK</u>  |                                 | 18. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u><br>DUE TO (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) <u>Heart disease Chronic coronary insufficiency</u> |                                 |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr...</u>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>420.0</u>  |                                 |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>3-21-</u> , 19 <u>54</u> , to <u>5-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/28/59</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.            |                                 |  |  |
| ACTUAL SIGNATURE <u>Theodore R. Pinckney</u> M.D.  |                                 | ADDRESS (Street, city or town, state) <u>4832 DEANE AVENUE, N. E. WASHINGTON 19, D. C.</u>   |  |
| DATE SIGNED  |                                 |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                                 | 22b. DATE THEREOF <u>6.17.59</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cemetery</u>  |                                 | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. McGuire</u>  |                                 | 24. REC'D BY REGISTRAR <u>JUN 16 '59</u>   |  |
| ADDRESS <u>1820-9th St N.W.</u>  |                                 | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>   |  |







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07149

## 7117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |  |  |  |   |   |  |                                  |
|--|--|--|--|---|---|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>                 |   |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Arden</b> |  |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>Fulton Avenue</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hattie</b> Middle <b>Mae</b> Last <b>Young</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7,</b> Year <b>19 59</b>   |   |  |                                  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>col.</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>2--27--22</b>   |                                  |
| 9. AGE (In years last birthday)<br><b>37</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Switch board operator</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Florida</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Flora Pray</b>   |   |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)  |  | 17. INFORMANT<br>Address<br><b>Ernestine Smith; same address as # 2.</b>  |   |  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>416X</b> DUE TO <b>Rheumatic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)   |  |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |   |   |  |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)                               |  |   |   |  |                                  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |   |  |                                  |
| ACTUAL SIGNATURE <b>John T. Maloney</b>  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  |                                  |
| EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |                                  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 7, 1959</b>   |   |  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>6-12-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>First Bapt. Church Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Glen Arden, Maryland</b>           |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Fraziers Funeral Home, Inc.</b>   |  |  |  | ADDRESS<br><b>389-R.D. Ave. N.W. D.C.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DATE JUN 10 '59</b>                                      |                                  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. House</b>  |   |  |                                  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07150

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Prince Georges</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aquasco</u><br>c. LENGTH OF STAY IN 1b <u>1 hr</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 1587B Route #1</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aquasco</u><br>d. STREET ADDRESS <u>Box 1587B Route #1</u><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Lyone</u> Middle <u>Quinton</u> Last <u>Young</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>June</u> Day <u>1</u> Year <u>1959</u>   |  |  |  |
| <b>5. SEX</b><br><u>Male</u>   |  | <b>6. COLOR OR RACE</b><br><u>Colored</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>Dec 16, 1958</u>  |  |  |  |
| <b>9. AGE</b> (In years last birthday) <u>5</u> yrs. <u>14</u> Months <u>7</u> Days <u>4</u> Hours <u></u> Min.  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>None</u>  |  |  |  |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U. S. A</u>   |  | <b>13. FATHER'S NAME</b><br><u>Thomas Edward Walton</u>  |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Elsie Young</u>  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u><br>(If yes, give war or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>  |  |  |  |
| <b>17. INFORMANT</b><br><u>Mr. Elsie Young, same as #2</u>   |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>491X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u><br>DUE TO (c) <u></u> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  |   |  |  |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/></b>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>19</u> a. m. <u></u> p. m.   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| <b>20f. (City or town)</b>   |  | <b>(County)</b>   |  | <b>(State)</b>   |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |
| <b>ACTUAL SIGNATURE</b><br><u>James I. Boyd</u>  |  | <b>EXAMINER'S NAME (Type)</b><br><u>JAMES I. Boyd</u>   |  | <b>CHIEF MEDICAL EXAMINER <input type="checkbox"/></b><br><b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b><br><b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>22b. DATE THEREOF</b><br><u>6-1-59</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>St Thomas</u>  |  |  |  |
| <b>22d. LOCATION (City, town, or county)</b><br><u>Aquasco</u>   |  | <b>(State)</b><br><u>M.D.</u>   |  | <b>DATE SIGNED</b><br><u>June 1, 1959</u>  |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>George H. Nelson</u>   |  | <b>ADDRESS</b><br><u>Aquasco</u>  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>6/1/59</u>  |  |  |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>  |  | <b>DATE</b> <u>6/1/59</u>   |  |  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077 162XV2

